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August 6, 2004

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RE: State Survey Agency Response to Iowa Protection and Advocacy Services, Inc. July 9, 2004 Report

Dear Mr. Shumate:

You have requested that the Iowa Department of Inspections and Appeals (Department) provide a response to the July 9, 2004, report issued by Iowa Protection and Advocacy Services, Inc. (P&A), issued with a press conference and presentation to the Governor's Office. P&A acknowledges that its findings present only a "cursory review." P&A's review appears to be its first attempt to extend its limited advocacy oversight for individual clients with disabilities into providing broad commentary on the application of the Health Facilities Division's (Division) policies relating to the survey and certification practices in long term care facilities. The Department's interaction with P&A before the issuance of its report had been minimal.

P&A's "sole purpose" of its review, it claims, is to "ensure accurate final reporting." P&A concludes that violations of regulatory standards identified by the Division central office in the final report card of performance (known more appropriately as Form CMS-2567L, Statement of Deficiencies and Plan of Correction)[1] posted on the Department's website, do not accurately reflect findings noted by field survey staff. P&A asserts that the Division's findings, as reported to your agency, are "clearly understated either by oversight or by intention." P&A calls upon Iowa's Governor to examine this issue to ensure that reporting of findings is accurate.

As you will see, the Department's response contradicts P&A's conclusions. P&A did not speak with anyone from the Department when conducting its review. P&A did not provide the Department with a copy of its report. On the day the report was published, P&A was asked to meet with Department

[1] Federal violations are identified as "deficiencies." Deficiencies at the State level are identified as "violations." For ease of reference, the term "violation" will be used in both contexts. Report of serious state violations are recorded on a State Citation Form.

representatives to discuss the report's findings. P&A declined, indicating it would be "premature" to meet. If P&A had met with the Department while conducting its review, it might well have gained an important, accurate understanding of the survey and certification process—how it is applied in conformance with strict regulatory guidelines. As the Department's response suggests, P&A was premature in issuing its report without having a complete understanding as to how the process is to be applied pursuant to federal and state mandates.

P&A's report received significant media coverage, which unnecessarily raised public angst. Two articles appearing in *The Des Moines Register* (July 9 and 10, 2004) are enclosed. P&A's report was apparently made available to the media at least the day prior to the press conference, as the Department was asked to comment on the report's findings during the afternoon of July 8. The Department was unable to provide comment, as this was the first we had heard about any report, or P&A's interest in the application of the survey and certification process. Iowa Senator Charles Grassley's July 7, 2004 letter to CMS' Administrator Mark McClellan was, likewise, critical on a national level. The media, too, reported on this letter on July 13, 2004 (enclosed). Finally, a recent editorial alleging Iowa has lost integrity with respect to regulatory oversight of nursing homes highlights a factual scenario alleging poor treatment of a resident. The inference to be drawn from this reference is that the Division is failing to respond to these issues, and failing to hold accountable those who are responsible. The editorial is also enclosed (*The Des Moines Register* July 25, 2004). The P&A report and media coverage prompted your written request to provide a response. The Department's response directly examines and answers the various issues touched upon by these sources.

There has been, using legal jargon, "detrimental reliance" on P&A's report. The Department welcomes the opportunity to "set the record straight" and to put to rest any concern generated by misinformation.

State Survey Agency Authority and Performance:

As you know, the Division is the state survey agency used by the Centers for Medicare and Medicaid Services (CMS) to perform survey and review functions for Medicare and Medicaid. See 42 CFR §488.1; See also Belle Plaine Nursing Home and Rehab Center v. DIA, 1999 WL 975852 (Iowa App. 1999). The State Operations Manual (SOM) provides the detailed guidance directing the Division's application of the regulatory process. Additionally, the Division is charged under state law with the statutory duty of licensing and inspecting all health care facilities in Iowa. See Iowa Code §135C.16; See also Stacyville Community Nursing Home v. DIA, 528 N.W. 2d 557, 558 (Iowa 1995). Other provisions in state law also mandate Division regulatory oversight (e.g., assisted living, elder group homes, adult day, etc.).

The Division's regulatory workload is significant, with 1,748 federally certified or state licensed/certified facilities and programs. P&A's self-admitted cursory review of six facilities amounted to examining around one-third of one percent of the Division's workload. Upon a thorough review of the six facilities mentioned in P&A's report, there were 60 "potential" violations reported by field survey staff in advance of the federally mandated supervisory review called for by CMS' Principles of Documentation. The required review removed two possible violations due to failure of documentation (e.g., inadequate documentation to support a regulatory violation). In other words, 96.7% of the potential violations reported by field staff in advance of the supervisory review were cited with appropriate reference to regulatory citation, and adopted as final.

Each year CMS assesses the performance of the Division, as well as all other state survey agencies around the nation. The last CMS annual review of the Division's performance closed out the federal fiscal year (FFY) ending September 30, 2003. One of the multiple performance standards upon which the Division is graded deserves mention. **"Standard 2"** relates to the supportability of survey findings. This performance indicator gauges whether the Division explains and properly documents all violations on the Form CMS-2567L. The threshold criterion used by CMS to judge whether the Division supports its survey findings states:

> **"No less than 85% of deficiencies cited on the Form CMS-2567L reviewed meet the Principles of Documentation for deficiency citation."**

The Division's most recent CMS annual review reflects that 94% of the statements of deficiency measures rated met the Principles of Documentation for deficiency citation. Further, with regard to scope and severity reflected in the Division's findings (whether appropriate violations were identified), on average, 91% were accurately reflected. The upshot of these performance indicators is that the Division not only met, but exceeded CMS' performance standards for supportability of its findings.

Throughout each year, the Division's survey activity is scrutinized in depth by CMS. This is accomplished in two ways. First, by comparative surveys where CMS surveyors go into a facility recently surveyed by the Division and compare their survey results with those reported by the Division. Second, CMS conducts Federal Oversight/Support Surveys (FOSS), during which federal surveyors observe and evaluate the Division's performance at the time of the survey. The reports of this multi-tiered federal oversight have consistently shown that Iowa surveyors meet or exceed the standards set forth by CMS. For example, in April 2004, a federally certified surveyor wrote, following a FOSS: "The Iowa surveyors conducted investigations characterized by skillful collection, integration, and coordination of information. All of their gathered information was factual, relevant to the quality of the facility performance, and corroborated with a variety of other sources of evidence whenever possible. Their investigations were comprehensive and reflective of the extent and magnitude of deficient practice within the facility." This example is the rule, not the exception.

An important consideration to be examined relative to P&A's report is the qualifications of its reviewers. During CMS' multiple assessments of the Division, federally certified surveyors are always used. They are familiar with CMS' prescribed application of operational guidelines and the required Principles of Documentation. To our knowledge, none of P&A's reviewers are federally certified surveyors, and it is uncertain if they are even licensed healthcare professionals. Failing either of these necessary professional qualifications, it is doubtful P&A's reviewers would have the requisite training or experience to fairly assess records or provide meaningful comment on the application of the survey and certification process. Regardless of their expertise, P&A's report contains numerous errors and omissions, as noted below.

P&A Statutory Authority:

Contrary to media reporting (*The Des Moines Register*, July 9, 2004), P&A is not a federal agency. Rather, P&A is a private, non-profit Iowa corporation with a 10 member Board of Directors. P&A was created under federal law to serve individuals with disabilities. It operates under three different federal statutes, enacted at different times, and a series of regulations implementing each statute. In addition, P&A also operates under relevant state statutory authority. The federal and state authorizing statutes are described below.

Federal Law: In response to the "inhumane and despicable conditions" discovered at an institution in New York serving persons with developmental disabilities, Congress enacted the Developmental Disabilities Assistance (DDA) and Bill of Rights Act of 1975. This original statute was amended in 2000, and is now codified at 42 USC sections 15001-15115. The Congressional history reveals that Congress was very concerned about the conditions that existed and sought to remedy the conditions by creating an independent organization empowered with statutory authority to investigate, advocate, monitor and take appropriate action to "protect the human rights of this vulnerable population." Iowa Protection and Advocacy v. Gerard, 151 F.Supp. 1150, 1157-1158 (N.D. Iowa 2001). In order to receive federal funds under the DDA statute, and so as to ensure the creation of independent agencies in each state, each state must have in effect a protection and advocacy program. Iowa receives DDA and mental health funding upon assurances that it has a protection and advocacy program. In Iowa, that program is P&A.

In 1986, Congress passed the Protection and Advocacy for Mentally Ill Individuals Act. 42 USC §§ 10801-10827. Congress found that individuals with mental illness are vulnerable to abuse, neglect, and serious injury and that state systems for monitoring the rights of these individuals varied widely and were frequently inadequate. 42 U.S.C. §10801(a). This statute was modeled after the DDA. Under this legislation, P&A has broad authority to investigate, advocate, monitor and take appropriate action to protect the rights of persons with mental illness. In addition, P&A has specific statutory authority to investigate abuse and neglect. 42 U.S.C. §10805(a)(1)(B).

In 1993, Congress extended the protections of the above referenced statutes to persons with disabilities generally by enacting the Protection and Advocacy of Individual Rights program. 42 U.S.C. §794e. The persons covered under this statute include disabled persons not covered by the other two statutes. 42 U.S.C. §794e(a)(1). Under this statute, P&A also has broad authority to investigate, advocate, monitor and take appropriate action to protect the rights of persons with disabilities.

Access to records, including confidential records, is expressly authorized under all three statutes. Federal law preempts state law in this area. Iowa Protection and Advocacy v. Rasmussen, 206 F.R.D. 630, 638-640 (S.D. Iowa 2001). P&A has authority to investigate an incident even though it has not received a specific complaint from the individual affected, and it has specific authority to review reports prepared by any agency charged with investigating abuse or neglect. Id.

Funding for P&A is provided by the federal Department of Health and Human Services (HHS). Among other things, P&A's application for funding must contain an annual statement of objectives and priorities. 42 U.S.C. §794e(f). P&A's FFY04 priorities approved for funding by HHS included the priority that P&A "will identify and investigate system failures of regulatory and/or investigatory agencies that have resulted in harm to, and or violation of, civil rights of individuals with disabilities."

State Law: Iowa Code section 135C.2 (4) provides that P&A is "recognized as an agency legally authorized and constituted to ensure the implementation of the purposes of this chapter for populations under its authority...." In addition, Iowa Code section 135C.16 provides P&A with authority to conduct investigations in chapter 135C facilities. Significantly, Iowa Code section 135C.17 provides that, "[I]t shall be the duty of the department to cooperate with the protection and advocacy agency by responding to all reasonable requests for assistance and information as required by federal law and this chapter." Iowa Code section 135C.19 provides that the department is obligated to provide P&A with copies of all citations.

In summary, P&A's statutory authority centers on investigating and advocating for individuals with "disabilities." P&A's FFY04 priorities include examining "system failures" of agencies responsible for investigating actual harm to, and or violation of, civil rights of individuals with "disabilities." As evidenced by its report, P&A has extended its authority to reviewing the application of the survey and certification process. The apparent absence of relevant experience and training in this process perhaps provides some explanation for P&A's misguided conclusions.

"Process" Overview:

The Division licenses, inspects and provides regulatory oversight over a vast array of health care providers in Iowa. The Division is the "state survey agency" for purposes of determining compliance with governing federal certification requirements for health care providers that are certified to participate in federal funds (Medicare and Medicaid). The Division's statutory and certification duties are discharged so as to ensure the health, safety, and welfare of those Iowans receiving services from the health care providers it licenses and certifies.

Pursuant to Iowa Code chapter 135C, the Division licenses and inspects all health care facilities in Iowa. This chapter covers the licensure and inspection of nursing facilities, residential care facilities (including the special categories of small bed Residential Care Facilities), intermediate care facilities for persons with mental retardation, and intermediate care facilities for persons with mental illness. Iowa Code §§135C.1, 135C.2, 135C.3, 135C.4 135C.9, 135C.16 and 135C.38 (2003). To implement this chapter, the Division promulgated twelve (12) chapters of administrative rules that must be applied in the inspection process. 481 IAC chapters 50, 54, 56, 57, 58, and 60-66.

In addition, pursuant to Iowa Code chapter 135B, the Division licenses and inspects hospitals. Iowa Code §§135B.4, 135B.7, and 135B.9. See also 481 IAC chapter 51. Pursuant to Iowa Code chapter 135H, the Division licenses and inspects Psychiatric Mental Institutions for Children. Iowa Code §§ 135H.1, 135H.5, and 135H.6. (2003). See also 481 IAC chapter 41. Pursuant to Iowa Code chapter 135J, for those facilities opting to be licensed, the Division may license hospice programs. Iowa Code §§135J.1, 135J. 2 and 135J.4 (2003). See also 481 IAC chapter 53.

The Division is also the state survey agency for CMS for purposes of determining whether a health care provider certified to participate in federally funded programs has satisfied the certification requirements imposed under federal law. As such, the Division regularly inspects skilled nursing facilities, nursing facilities, hospitals, home health agencies, and end stage-renal dialysis facilities. In the inspections performed in skilled nursing facilities and nursing facilities, the Division must apply the federal statute found at 42 U.S.C. 1396r et. seq. and the federal regulations found at 42 CFR parts 483 and 488. To guide the Division in the application of these complex federal laws, CMS developed the State Operations Manual for Provider Certification (SOM). The SOM is a comprehensive manual detailing the application of the federal standards and the survey/certification process. The SOM consists of eight substantive chapters, one chapter of exhibits, and lengthy appendices. It contains literally hundreds of pages of instructions for survey staff and supervisory personnel. The SOM is provided by CMS as a tool to assist state survey agencies, in this case the Division, in determining whether nursing facilities are in compliance with federal regulations.

In Iowa, the Division applies the SOM's survey protocol when determining compliance with state regulations. Dubuque Nursing and Rehabilitation Center v. DIA, 2002 WL 31529172 (Iowa App.

2002). In other words, the same detailed process is used in both federal and state survey and certification processes.

Licensure and certification surveys involve on-site inspection, fact gathering, interviews, clinical record review, and direct observation of nursing care, treatment and services by field surveyors. The information gathered in the field by the Division's trained and Surveyor Minimum Qualifications Test (SMQT) certified surveyors is transmitted to the central office for both supervisory review and, when warranted, compliance officer review. Upon the completion of central office review, three different reports may be issued. Those reports are:

- As mentioned previously, Forms CMS-2567L and CMS-2567A (these forms recite the noncompliance with federal standards detected during the survey/complaint investigation);
- State Citation (this form sets forth noncompliance with state law standards and is only issued when the Division (e.g., the Compliance Officer) has determined that the state law violation is egregious enough to warrant a Class I, II, or III citation and associated fine under Iowa Code section 135C.36); and,
- State Statement of Deficiencies (this form recites state law violations that were detected at the time of survey, but which are not serious enough to warrant a citation).

The following state and federal law citations direct the Division's processing of potential violations:

- Iowa Code section 135C.38 provides that the Division shall use a preponderance of the evidence standard in substantiating complaints regarding care, treatment and services;
- 42 CFR section 488.312 provides that the state survey agency must implement programs to measure accuracy and improve consistency in the application of survey results and enforcement remedies;
- 42 CFR section 488.318 provides that the Division can be sanctioned (including reduction in federal funding) for inadequate survey performance. Inadequate survey performance includes failure by the Division to cite only valid deficiencies, failure by the Division to use federal standards, protocols and forms, and failure to conduct surveys in accordance with the federal rules;
- 42 CFR section 488.330 provides that the Division surveys for compliance or noncompliance with the federal requirements and that a state survey may be followed by a federal validation survey (referred to previously as a FOSS);
- 42 CFR section 488.110 sets forth the procedural guidelines that must be used in the survey process. This regulation sets forth a series of tasks that must be completed. "Task 7" details the process for formulating and issuing the deficiency statement;
- 42 CFR section 488.110 provides that the deficiency statement contains the information concerning negative findings and cautions the surveyor to include only that information that could possibly contribute to a deficiency. Once compiled, under this regulation, the survey team meets to review the summaries and is specifically directed to consider information submitted by the facility to address any observed concern. Following this meeting, the team completes an exit interview at the facility (Task "8") in which the facility is informed of concerns and that the survey information will be transmitted to the Division's Central Office for supervisory review;
- 42 CFR 488.110 mandates supervisory review. This review ensures that the Division has: a system to measure accuracy and improve consistency; a mechanism to ensure adherence to the federal survey process so as to avoid sanction for inadequate survey performance; a

system to ensure that the preponderance of the evidence standard has been met; a process for ensuring that the federal guidelines for survey tasks have been followed (including Appendix "P" and the Principles of Documentation); and a system for Compliance Officer review of survey findings for purposes of determining whether a state Citation should be issued; and,

- 42 CFR section 488.26 provides that all surveyors must use federal forms and that the Division must use the survey methods and procedures prescribed by CMS. As previously indicated, the Division applies the SOM's survey protocol when determining compliance with state regulations.

As expected, this process is both paper and labor intensive. Field surveyors forward to Division supervisory personnel the survey packet (worksheets, notes, copies of clinical records) for review and compilation of final disposition of the survey's activity. Depending upon the size of a facility and its compliance history, two to four field surveyors will conduct a survey, which might take an entire week. The team's lead field surveyor will, on the **"Performance Standard Three Tag Review Form,"** note potential federal and state violations. Narrative describing a potential violation at issue, and examples of non-compliance, are also provided in a prescribed format. The team's lead field surveyor also completes the Division's **"Citing and Fining Determination Form,"** which reflects whether the field survey team has cited potential deficiencies that might be considered for federal and/or state monetary fines (potential situations relating to the mandatory denial of payment for Medicare/Medicaid residents would be included). This phase of the process is referred to as "determination."

Among the other forms prepared by the field survey staff that has a direct relationship to determination is the **"Factor Form,"** which documents the factors to be evaluated when determining the appropriateness of a proposed violation. The Program Coordinator and Bureau Chief, along with a Compliance Officer, meet to discuss a potential violation. A thorough review is made of the survey packet. Throughout this process, the federally mandated **Principles of Documentation** are considered and applied to ensure that a cited violation meets evidentiary standards. Even when proposed violations do not rise to the level requiring determination, supervisory personnel closely scrutinize them. As necessary, consultation will be had with the field survey team regarding issues identified in the review process. If a violation has multiple elements (examples) and any element is deleted or added as a result of the review, the "scope" of the violation will be evaluated and adjusted to meet federal scope/severity requirements. Following the mandated supervisory review, required, appropriate edits/rewrites are made to the potential violations and the **Form CMS-2567L** is computer inputted into the federal database **(ASPEN)**. Rationale for supervisory adjustments is noted on the **"Performance Standard Three Tag Review Form."** Concerns not rising to the level of a violation are noted on **Form CMS-2567A**. The report citing federal and state violations is placed on the Department's nursing home report card website three days after the findings are mailed to the facility.

As this overview indicates, the survey process and its application are very complex and demanding. It is designed to ensure, to the fullest extent possible, consistency in Division findings. Someone unfamiliar with the process and its application might well mistakenly rush to judgment regarding the Division's performance. There are always two competing interests in a regulated environment. Balanced against the advocacy community is the provider industry. Advocates, generally speaking, are of the opinion that regulators do not do enough. Industry often criticizes the regulator for being too tough. In fact, over one-third[2] of the reports citing violations in nursing facilities are challenged on appeal. These aggressive challenges to the Division's findings suggest that the Division is not at all soft on regulatory

[2] In CY02, 38.3% of the reports citing violations were challenged at informal dispute resolution. 34.6% were challenged in CY03. Extrapolating from the first six months of CY04, 40.7% of the Division's report of findings will be challenged.

enforcement. One might conclude that the Division has it right when both sides level criticism. Not long ago legislative complaints focused on the "too aggressive" enforcement by the Division.

Access to Records:

P&A, by federal statute, has unfettered access to otherwise confidential records contained within the Division's files. Access is granted when the Division reports its findings. A facility challenging violations cited by the Division has access only to the records related to that appeal. In other words, the general public and the media only have access to the final report of findings as depicted on Form CMS-2567L and Form CMS-2567A. Drawing conclusions and inferences from either form without the benefit of knowing the underlying facts would not provide a complete picture of the Division's analytical decision making at the supervisory level. Even knowing the underlying facts would be nearly meaningless unless a reviewer possessed the requisite training and experience to understand the application of the process and the specified rationale supporting analytical decision-making.

Preliminary Observations:

With the prescriptive rules mandating the Division's regulatory oversight in mind, and before providing a detailed response to the findings on the six facilities reviewed by P&A, a few matters deserve special mention. The "Introduction" section of P&A's report highlights two findings from the July 17, 2003, General Accounting Office (GAO) report on nursing homes that cause P&A concern. One relates to the alleged predictability of the survey cycle – when facilities might expect to be subject to its mandatory annual survey. P&A emphasized this concern by having a resident from a nursing facility comment on the issue at its press conference. This resident alleged that facilities essentially "rig" the system by increasing staff when they guess the Division might conduct its annual survey. Another concern highlighted by P&A relates to a decrease in the number of serious violations cited by the Division, despite an increase in complaints. One issue not mentioned in P&A's report, but highlighted on occasion by local media, relates to an Office of Inspector General, Department of Health and Human Services, March 2003 report. This report indicates that the Division "removed" 25% of the potential findings by field survey staff after supervisory review. Finally, several examples of serious allegations of poor care are mentioned in the enclosed newspaper clippings. The reference to these incidents appears deliberately meant to create the inference that the Division is inappropriately responding to serious violations.

Alleged Predictability of Surveys: P&A concludes that nursing facilities successfully predict when the Division will survey them because 31.1% were surveyed within 15 days of its prior year's survey. P&A asserts that Iowa was the most predictable. The GAO report indicates that one-third of the most recent state surveys nationwide remained predictable – a slight reduction from facilities' prior surveys, where about 38% were predictable. The concern about predictability of surveys, so GAO alleges, can allow quality of care problems to go undetected because facilities, if they choose to do so, may conceal certain problems such as staffing.

P&A does not indicate where it acquired its data. The most current data (as of July 20, 2004) maintained by CMS indicates there was a fourteen (14) day or less window of predictability in 27% of the surveys conducted by the Division. Stated another way, 73% of the Division's surveys can't be predicted with any certainty. Complaint investigations are conducted without notice to the facility. Only one of the six facilities reviewed by P&A was surveyed within fifteen (15) days or less of its prior annual survey (i.e., 83% unpredictability). This single "predictable" facility, if you will, was visited

four times by Division staff in the twelve (12) months preceding P&A's report. The deterrent effect against trying to "game the system" is significant. An additional deterrent is impacted by a federal performance standard perhaps unknown to P&A. At least 10% of the Division's surveys must be after hours and on weekends. The Division also meets and exceeds this standard.

The Division does not discount that some facilities might "staff up" during a survey. However, such attempts can be detected in any number of ways. For example, interviews with residents or advocates during a survey or complaint investigation should reveal this as a potential concern. Staff personnel records can be checked, which might suggest staffing irregularities. More importantly, systemic issues (e.g., bed sores) can't be remedied during a survey by increasing staff. This potential program deficiency could well lead a surveyor to examine staffing history and trends.

The ability to schedule surveys so as to not be somewhat predictable under the current mandated system is fairly restrictive. Each skilled nursing facility is subject to a standard survey not later than fifteen (15) months after the date of the previous standard survey. However, the statewide average interval between standard surveys must not exceed twelve (12) months (not to exceed a 12.9 average). 42 U.S.C. §1396r(g)(2)(A)(iii). The Division meets this performance standard with one exception. During the performance review ending FFY September 30, 2003, one nursing home's annual survey exceeded the fifteen (15) month cap. A total of 371 surveys were conducted. The Division conducted 99.7% of its surveys within the standard. The average statewide interval between consecutive surveys was within standard at twelve and a half (12.5) months. The one exception is highlighted to indicate how rigidly the Division's performance is monitored by CMS.

In the last several years, the Division has been significantly affected by a reduction in trained and experienced field survey staff (retirements, early outs, leaving state government for more lucrative salaries with industry, leaving because of the demands of the job with respect to excessive overnight travel, promotions, etc.). Survey and complaint investigations are the responsibility of 69 field survey staff. Since October 1999, 80% of that staff has turned over (55 of 69). The Division's ability to be unpredictable is directly impacted by the number of trained and experienced staff dedicated to this process, and the number of complaints received. The training required to SMQT qualify a surveyor is extensive and time consuming. Further, in the past years, complaints received by the Division have increased dramatically, nearly doubling. Complaints are triaged according to their severity. The more serious complaints have to be investigated more promptly. Field survey staff conducting annual surveys are also used to conduct complaint investigations. The Division's best intention to be "unpredictable" more than 73% of the time is adversely impacted when limited trained and experienced staff resources are diverted to time sensitive complaint investigations. Schedules are adjusted to meet time sensitive demands, while at the same time meeting mandated survey performance targets. The Division has adjusted to the increase in complaints by using Complaint Unit central office staff and supervisory personnel to ensure performance targets are met, among other measures.

To ensure appropriate regulatory oversight is prioritized, and to mitigate the alleged predictability factor, the Division creatively developed a tracking system for 16 of the state's chronic poor performing nursing facilities. Within a recent twelve (12) month span of time, staff conducted 182 on-site visits at these facilities, for an average of 11 visits per facility. These visits generated 775 federal and state

violations (23.5 federal deficiencies per facility).[3] Civil Money Penalty (federal) and Fining and Citation (state) totaled nearly $225,000. The only predictability at these facilities is that the Division has an effective, prominent, recurring regulatory presence.

One ought conclude that the Division is doing an outstanding job relative to being unpredictable, given all of the issues highlighted. An outside commentator unfamiliar with the application of intricate processes might not fully appreciate the competing demands placed on the Division. While perhaps well intentioned, uninformed comments do not serve the public. Rather, such comments tend to foster unnecessary and unjustified fears.

Increased Complaints and relevance to Deficiency Citation: P&A suggests that the increased number of complaints received by its office and the State's Long Term Care Ombudsman should result in a corresponding increase in the number of serious violations cited by the Division. Referencing the GAO report, P&A notes that the Division is citing fewer serious violations than in previous years (the reporting periods date back to January 1997, through January 2002). P&A mistakenly mixes "apples and oranges" when it makes this observation.

The GAO report relates to some violations, as we interpret the relevant appendix, not to all violations cited during the annual survey process, which might include revisits. It is our understanding that the GAO report does not reflect data related to complaints. P&A's attempt to correlate these numbers is misplaced. Moreover, the increase in complaints correlates to an increase in the filing of mandatory reports of dependent adult abuse by Iowa's mandatory reporters. These reports are included in the Division's statistics, but do not relate to findings concerning a facility. Rather, dependent adult abuse investigations result in findings that are transmitted to the Iowa Department of Human Services' central registry, not violations transmitted to CMS. In fact, founded dependent adult abuse reports are confidential under Iowa law, and are not communicated to the GAO.

Notwithstanding P&A's misapplication of unrelated statistics, the Department believes, there is no direct correlation between the increase in the number of complaints received by P&A and the State's Long Term Care Ombudsman, and the level of violations expected to be cited by the Division in response. In fact, P&A should know that, much like the State Long Term Care Ombudsman, a good number of the complaints they receive are handled internally – the complaints are never referred to the Division for action. The reason they are not referred to the Division is because they do not rise to the level of a regulatory violation after applying applicable standards. The heightened awareness of the Division's presence in nursing facilities, due to numerous complaint investigations, and the increased frequency of Division visits to identified troublesome facilities, have a potential positive impact to reduce violations. The Division also initiated a creative program whereby during the year nursing home staffs are invited to participate in training initiatives with state survey staff. National speakers of prominence deliver presentations on "hot topic" issues. This initiative has had, one could conclude, a positive impact on mitigating serious violations. Advocates might benefit from similar training so they, too, will appreciate the application of the processes they may misunderstand.

[3] Iowa Code section 249A.19 prohibits the Division from collecting a state fine for any violations for which a federal Civil Money Penalty (CMP) has been assessed. In other words, a state fine is "stayed" unless and until the federal CMP no longer exists. In addition, 42 CFR 488.436 provides that if the facility waives its right to a hearing, the facility shall receive a 35% reduction in the CMP assessed. This is mandatory. These mandates have long been confused by the media to suggest the Department waives state fines and reduces federal CMPs to the detriment of regulatory enforcement.

The GAO report makes an interesting observation relative to factors it believes contribute to underreporting of serious violations. Specifically, GAO cites "inadequate state supervisory review of surveys" as a potential factor contributing to underreporting. As previously indicated, 42 CFR 488.110 mandates supervisory review of field surveyor work, applying strict standards. This review ensures that the Division has: a system to measure accuracy and improve consistency; a mechanism to ensure adherence to the federal survey process so as to avoid sanction for inadequate survey performance; a system to ensure that the preponderance of the evidence standard has been met; a process for ensuring that the federal guidelines for survey tasks has been followed (including Appendix "P" and the Principles of Documentation); and a system for Compliance Officer review of survey findings for purposes of determining whether a state Citation should be issued. As noted previously, the Division meets and exceeds its federal performance standards on this review. Experienced and trained Program Coordinators and Bureau Chiefs take this responsibility very seriously.

It is ironic that at the same time GAO criticizes states for inadequate supervisory reviews, P&A criticizes the Division for not "rubber-stamping" potential violations identified by field survey staff. 42 CFR section 488.318 provides that the Division can be sanctioned (including reduction in federal funding) for inadequate survey performance. Inadequate survey performance includes failure by the Division to cite only valid deficiencies. Comparative surveys, FOSS and annual performance evaluations, all conducted by CMS experts, are more reliable indicators of the Division's performance than "cursory reviews" by those who may lack the requisite training and experience to even begin to evaluate application of the process.

It is entirely appropriate and necessary that field survey staff proposals be adjusted during supervisory review to ensure that only valid violations are identified in the Division's report of findings. As previously indicated, 80% of the Division's field survey staff has turned over in less than five (5) years. Conversely, supervisory staff (Bureau Chiefs) have, on average, twenty-five (25) years of practical experience in the application of survey protocols. The training required to SMQT qualify field surveyors is extensive and time consuming. Once fully trained, expertise is gained only through extensive, practical field experience. Given this dynamic, it would be expected that field surveyor work product would and should be closely scrutinized. If the question is asked whether this equates to underreporting, the answer is "no." Certainly, it is not, in Iowa's case, the result of corruption by unscrupulous supervisors to make nursing home industry performance look better than it should. As for the six facilities reviewed cursorily by P&A, it should be noted that during supervisory review, four potential violations were actually increased on the scope and severity matrix. This fact was not noted in P&A's report, either by oversight or deliberately.

Lest we forget, the Division is the same state survey agency that very recently ordered the safe evacuation of residents in one nursing home, and closed two other facilities in the recent past. The Division is the same state survey agency that had been criticized by some as "Gestapo like" because of aggressive regulatory enforcement.

Alleged Removal of Deficiencies: Since the March 2003, publication of the Office of Inspector General (OIG) report, the media, on occasion, has used portions of that report to critique the Division's performance. The most recent reference to this report appears in *The Des Moines Register's* July 9 and 10, 2004 articles (enclosed).

"Appendix E" of the report purports to identify (by percentage) the number of deficiencies "removed" from "draft reports." In other words, the appendix purports to convey the percentage of potential

violations never making it to Form CMS-2567L. Iowa is reported to have removed 25% of potential violations—allegedly, Iowa led the nation in removing violations. The Division itself, in response to an OIG inquiry, mistakenly and incorrectly provided this percentage. In reality, the figure provided has nothing to do with "removing" violations from "draft" reports. It related to changes after the appeal process was complete. The Department has repeatedly attempted to correct the misunderstanding of this statistic by providing clarification. Apparently, there is a lack of interest in accurate reporting of the facts. The Division has never tracked or maintained statistics relative to adjustments following supervisory review—there is no mandate to do so. The Division's report to OIG contained the mistaken reference to 25%. This percentage actually represented the percentage of alternations of the final report following appeals. Challenges on appeal can occur via several mechanisms (e.g., desk reviews, informal dispute resolution and contested case proceedings).

Modifications to violations on Form CMS-2567L are required to be made following conclusion of independent reviews. For example, 28% of the total violations were modified in FFY02 following independent review. For FFY03, 34% were modified. For FFY04, 27% were modified. Continuing to draw attention to inaccurate information from the OIG report has the potential to misinform the public. The July 9, 2004 article further distorts facts when it unfairly and inaccurately extends the report's findings to "downgrading" violations. The relevant appendix speaks to "removing" violations, not "downgrading" them. This is yet another obvious error in reporting that serves no useful purpose. As noted earlier, of the six facilities reviewed by P&A, two potential violations out of a total of 60 were ultimately removed. In other words, 97% of the potential violations reported by field survey staff were adopted, in some form, following supervisory review.

Misleading Inferences: The enclosed newspaper articles provide a minute sampling of the issues investigated by the Division and reported on by the media. In many cases, reporting leaves to the reader's imagination the Division's alleged failure to effectively regulate. Noted below are the true facts unreported (and unknown) by the media. These facts present quite a contrast to the reported incidents, and the public would be well served if all relevant information were made a part of the story.

- It was reported that the Division "declined to fine a nursing home where one resident's abdomen was reported infested with maggots." It was reported that the Division cited the home "only for failing to follow a doctor's order related to hygiene." The obvious inference the writer wanted the reader to draw is that the Division marginalized a serious matter or, worse yet, that "higher ups" "erased" findings. (July 13 and 25, 2004, *The Des Moines Register*). The true facts, although undisclosed in reporting, tell a different story.

  An on-site complaint investigation established that the nursing home failed to seek clarification on a doctor's order. The investigation established that the presence of maggots was not the result of substandard nursing care but, rather, resulted from resident non-compliance. A review of the clinical records (something the media does not have access to) established that nursing staff responded appropriately. Additionally, the clinical records revealed that the resident's abdomen was not "infested with maggots."

  The Division received this complaint (July 5, 2002) from a dialysis center nurse indicating that a resident of a local nursing home had maggots in a Jejunostomy tube (J-tube) site. The resident resided in a nursing home, but received dialysis at a local clinic (a different health care provider) three times per week for end-stage renal disease. The resident had both a J-tube and Gastrostomy tube (G-tube). A J-tube can be used for administration of medication,

a G-tube for nutrition. This resident was frequently non-compliant with nursing staff, sat outside without a shirt, and removed the dressings covering the J-tube. The nursing home was in close proximity to a farming operation. While outside, the resident would have been exposed to whatever elements existed in the environment, including flies (the source for maggots). Nursing home clinical records were closely examined during the complaint investigation.

On June 22, 2002, nursing staff noted that the resident's J-tube was sticking out halfway. In accordance with facility J-tube policy and professional standards, the resident's physician was contacted for direction. The physician ordered that the J-tube be taped. The site was also to be checked at dialysis when the resident returned to dialysis. Facility records also indicate that the J-tube was checked the following day. On July 4, 2002, nursing staff noted that the J-tube was now sucked in. No infestation was noted. This again prompted nursing staff to appropriately contact the physician for orders. Nursing staff was ordered to dress and tape the site. While complying with the order, nothing unusual regarding the site was noted in clinical records. During this time, the resident continued visits outside to smoke, and continued to be non-compliant. No new orders were indicated, as the resident was to be seen the following day at dialysis. The dialysis clinic nurse identified the presence of maggots in the J-tube site the following day.

Information reviewed by a field surveyor indicated that in a warm, moist area, maggots could appear within eight hours after the eggs are laid. There was no evidence to suggest that the facility was culpable for the presence of maggots in the J-tube site between the last time nursing staff dressed and taped the site (July 4), and the following day the maggots were discovered at the dialysis center. A fly most likely laid the eggs while the resident was outside without a shirt on. There was no evidence to establish that the presence of maggots was caused by facility staff failure to follow nursing standards. Staff appropriately checked the area and maintained regular contact with the physician when problems were noted. Nursing staff also dressed the area in accordance with physician orders. The maggots were not the result of substandard nursing care.

Nonetheless, the facility was cited for a federal violation as a result of the Division's investigation. Investigation revealed that the facility failed to clarify an earlier physician order related to the J-tube. This order did not contain "specific" instructions. Nursing staff appropriately contacted the physician to clarify the order. The nursing staff left a message for the physician. However, the call was not returned. The facility finally received the clarifying order on July 5, 2002 (after the discovery of the presence of maggots). The Division cited non-compliance with a federal standard because the facility failed to re-contact the physician to get clarification of the earlier order. In other words, the facility was not off of the hook – it failed to follow up to clarify an order. Repeat calls should have been made until the necessary information was obtained to implement the earlier order. This failure, however, had no impact on the discovery of the presence of maggots the following day. Uniformed accusations suggesting that the Division responded inappropriately are unfortunate. They can be unsettling to the public and generate unnecessary and unwarranted anxiety about the Division's regulation and nursing home care in general.

- Another unfortunate accusation was made suggesting that the mistreatment of a resident at a nursing home by two caretakers was akin to the mistreatment of Iraqi prisoners. The

inference the writer wished the reader to draw from this piece was that the Division lacked the integrity to take appropriate responsive action. (July 25, 2004, The Register's Editorial, *The Des Moines Register*.) The truth can be found in the facts, if accuracy and fairness still matters.

This example of abuse involved two caretakers mistreating a resident by pouring powder in the resident's eyes, nose and mouth, then wrapping the resident in a urine soaked sheet and placing the resident in front of an air conditioner. Absent from the selective reporting of these facts is the detailing of the aggressive action taken by the Division. The nursing home in this case was cited for both federal and state violations. In addition, the caretakers were investigated and the Division issued founded dependent adult abuse reports on both. These individuals appealed their findings. The Division vigorously defended its findings and an independent administrative law judge affirmed both findings. There was absolute integrity in the Division's actions, selective reporting and editorializing notwithstanding. The public interest is not served by sensationalizing with erroneous, inaccurate, or incomplete information.

- Another example of effective Division response has been skewed to suggest otherwise. (July 9 and 10, 2004, *The Des Moines Register*.) Applying disconnected findings to suggest the Division is understating the seriousness of dependent adult abuse suggests an agenda other than reporting the true facts.

  It has been reported that nursing home caretakers have been held criminally liable for abuse of residents, as noted in hearings conducted by a sister state agency relative to unemployment benefits. Yet, as reported by the media, there is no mention of the abuse in the Division's findings following investigation. Further, it is reported, the Division does not always sanction the home. Simultaneous media reference to the GAO and IG reports are meant to bolster the inference that the Division is "routinely understating the seriousness of problems found in nursing homes."

  Although they may sometimes coincide, there is no necessary correlation between unemployment benefits hearings and actions taken by the Division in response to federal or state regulatory violations. It is entirely possible that a nursing home would act appropriately when confronted with alleged resident abuse by an employee caretaker (by investigating the matter, reporting promptly, and taking adverse action against its employee). If the nursing home acted appropriately and did not contribute to the abuse, it would be impermissible to levy a sanction against the home's license. This isn't Iraqi before liberation—due process of law is still relevant. Assuming that the Division makes a finding of dependent adult abuse against the caretaker, a referral is made to the Iowa Department of Human Services (DHS). That agency is responsible for inputting the finding in its central registry. Founded reports of dependent adult abuse are not reported on the Division's final reporting pursuant to law. Media sources know this. Suggesting the Division is underreporting serious incidents of abuse is reckless.

  In this particular situation, the Division investigated the incident and issued a founded dependent adult abuse report. A referral was made to DHS. There was no evidence that the facility engaged in a deficient practice – the facility acted appropriately. The former

caretaker has appealed the founded report of abuse. The criminal case has resulted in convictions under two of the four counts charged.

The public deserves complete and fair reporting.

Department's Review of P&A's Report:

P&A apparently rejects the Division's appropriate use of supervisory review, as mandated by federal law. Instead, P&A essentially insists that supervisors "rubber stamp" potential violations identified by field survey staff during survey and complaint investigations. Unfortunately, P&A misunderstands the appropriate, necessary federal survey process. Worse yet, P&A either intentionally omits or ignores important information from field survey staff, skews the information, or just plain gets the information wrong – leaping to an erroneous conclusion that "data being reported [by the Department] to the Federal agencies is clearly understated either by oversight or intention."

The following examination of the P&A's report shows in detail a nearly point-by-point analysis of P&A's "cursory review." This examination is, of necessity, replete with specific, voluminous, detailed information responsive to P&A's claims. It is the only way the Division can respond – thoroughly and factually.

A careful reading of this response will show two things. It will show that P&A's report is fatally flawed, and it will show that the Department is effectively performing its regulatory responsibilities. It is our hope and expectation that this response will eliminate unnecessary public anxiety generated to date by P&A's report and media attention.

The P&A report was based upon an admitted cursory review of six examples and was apparently not completed by persons trained and certified in the federal survey process. At the outset, it must be noted that surveyors lack authority to cite a deficiency or to sanction a non-compliant licensee. Rather, such agency action is taken only after mandatory supervisory review accompanied by full due process. Thus, all of the statements in the P&A reports that refer to surveyor citation are erroneous and likely based upon a lack of understanding of the actual federally prescribed process. In addition, a field surveyor lacks authority to assign the scope and severity assessed for a specific violation. The field surveyor completes tasks during the survey, but lacks all of the necessary information included in the scope and severity analysis. Scope and severity can only be assigned after careful analysis of the totality of violations detected. Thus, all P&A statements referencing scope and severity assigned by a field surveyor are similarly erroneous.

Nursing Home "A"

The P&A analysis of the Division's survey completed on 4/18/03 and the complaint investigation completed on 6/17/03 reported that the extent of the deficiencies cited in the "Final Report Card" was less than "may" have been supported in the "Surveyors' Notes." In the case of the survey completed on 4/13/03, P&A noted fifteen (15) "DIA Surveyor Notes" and nine (9) deficiencies cited in the "DIA Final Report."

There were six (6) tags (regulatory grouping) identified by P&A as having been noted by the field surveyor, but not in the final report of the survey. However, the surveyor's notes, observation and record review resulted in the conclusion that no violation was detected. Again, notations made by the field surveyors during the survey are not definitive. Isolation of any single notation is entirely

inadequate for purposes of determining compliance under federal and state law. An analysis of these six federal tags reveals the following:

P&A suggests that F153 should have been cited. F153 relates to resident rights. Field surveyor notes indicated that persons in the group interview were unaware that they had a right to look at their medical records. Although all of the "Residents Rights" information is covered at the time of admission and all residents receive a copy of those rights, it is quite likely that the residents at the group interview forgot or misplaced this information. The field surveyor notes established that there was no indication of prior knowledge of this concern by facility staff and no resident had been denied access to records. In addition, records were routinely and permissibly released to necessary treating professionals and institutions. Clinical records were available to residents. A deficiency under F153 could not be cited, but field surveyors shared the information with facility staff that the issue could be included in future resident council meetings.

P&A suggests that F164 should have been cited. F164 relates to resident privacy. Surveyor notes from group interview indicated a boy walked into the room of Resident #5 while the resident was on the toilet and "they do not pull privacy curtain." Department review indicates the surveyor did not cite a deficiency, as this resident said "it is better now and the staff knocks on doors." In accordance with facility documentation, the staff pulls privacy curtains and is trained to do so. An isolated concern regarding privacy that has been resolved to the resident's satisfaction does not support the conclusion that federal law has been violated.

P&A suggests that F174 should have been cited. F174 relates to privacy in resident phone use. Field surveyor notes from group interview indicated Resident #2 used a telephone in an open area with no privacy. Department review indicates a deficiency was not cited by field surveyors, as residents, when interviewed and expressly asked about phone use, did not voice objection to using the phone in the Activity Room or at the end of the hall. Use of this telephone would have been a matter of resident choice, not violative of law.

P&A suggests that F252 should have been cited. F252 relates to personal property. Field surveyor notes from group interview indicated Resident #5 lost underwear; Resident #6 lost blouse; Resident #2 and Resident #3 had money taken from his/her belongings; and Resident #1 had a Wal-Mart card taken from his/her belongings. However, follow up by the field surveyors revealed no evidence of prior reporting to facility staff of these losses. There was no evidence to suggest facility and/or staff culpability regarding these missing items; however, the field surveyors shared the concerns with staff.

P&A suggests that F314 should have been cited. F314 relates to pressure sores. P&A stated concerns that this harm level deficiency was deleted by Program Coordinators due to lack of information. The field surveyor notes indicated pressure sores for Residents #1, #2 and #4. These notations by the field surveyor are appropriate, as treatment and avoidance of pressure sores is an area reviewed during the survey. However, the notations are not tantamount to a violation. Department review of the field surveyor notes indicated there was insufficient information to support a deficiency. Resident #2 had a pressure sore on admission. The clinical record documentation indicated the facility implemented appropriate devices (i.e., special mattress pad) to help heal the area. There were no indicators the facility was not treating this area appropriately. With regard to Resident #1, the field surveyor's notes did not contain information from which to determine when the pressure sore occurred, or if this was a new area. In addition, there were no documented observations of facility omissions in treating the area. Resident #4's position was being changed and they were using pressure-reducing devices. This resident

was receiving appropriate treatment. Thus, although all three residents were noted and reviewed during the survey, there was no evidence of deficient care for these three residents. Citation was neither supported, nor warranted.

P&A suggests that F324 should have been cited. F324 relates to resident supervision. The field surveyor notes indicated supervision and fall issues for Resident #14. P&A stated concerns that this harm-level deficiency was deleted by Program Coordinators. Department review indicates the documentation did not support a deficiency. Review of the clinical record documentation indicated the facility had tried numerous interventions with Resident #14, and the family refused other interventions. Staff tried using a baby monitor in the room, a low bed and mattress on the floor. The ombudsman was contacted about falls. The resident refused to wear a helmet. The facility briefly tried restraints and a Merry Walker, which didn't work. Additionally, the clinical record documented that the family expressly rejected other interventions identified by the facility as worthy of consideration. Again, citation was not supported, or warranted.

Of the nine (9) deficiencies cited by the Division after supervisory review as a result of this survey, P&A took issue with three (3) tags. These are summarized below.

P&A claims the Division failed to cite F246. F246 relates to quality of care. The surveyor notes contained information relating to the provision of positioning devices for Resident #6 and Resident #9. The final report does contain a deficiency at F246 with Resident #9 listed as an example. Department review indicates the final report did not include the example of Resident #6, as there was not deficient practice associated with positioning devices for this resident. The Program Coordinator did not delete the federal tag, and the scope and severity rating of this deficiency was unaffected by the omission to cite Resident #6 as an example.

P&A also claims error by the Division related to F309. F309 relates to assessment. According to P&A, the field surveyor notes indicated that Resident #7 lacked assessment for frequent falls, Resident #2 lacked assessment for weight loss, and six (6) other residents were identified with significant weight loss. Resident #4 was identified regarding not receiving oral hygiene and Resident #2 for dirty feet. Department review of the documentation indicated that none of the six (6) residents experienced significant weight loss. It was further noted that Resident #2 was not included in the field surveyor notes as having dirty feet. The only reference to dirty feet was noted six months prior to the survey in Resident #2's clinical record. Resident # 1 was flagged for weight loss on the QI/802 Form, but the facility was addressing this with appropriate interventions. Resident # 3 was flagged for weight loss, but actually did not sustain weight loss, which the facility was still monitoring. Resident #5 was flagged for weight loss, having lost four pounds in one year. However, the facility had appropriate interventions in place for this resident. Resident #6 was also flagged for weight loss. However, the facility was addressing the issue and providing appropriate interventions for this resident. Resident #13 was flagged for weight loss, having lost eight pounds in one year (not a significant weight loss under the CMS guidelines). However, the facility was addressing this and providing appropriate interventions. Resident #15 was flagged for weight loss of 10% in six months prior to admission. The Resident's weight was stabilized while in the facility.

P&A also suggests Division error regarding F312, which relates to quality of care. According to P&A, the field surveyor notes indicated Resident #5 was not receiving oral hygiene care, and Residents #6 and #10 were identified as having dirty feet. The P&A report also indicates that the Division Final Report failed to identify both Resident #4 regarding not receiving oral hygiene and Resident #2 for dirty feet.

Department review indicates Resident #4 was not included due to lack of information. The surveyor documented this resident did not receive oral care before breakfast, but there was no information available to indicate staff failed to brush teeth after breakfast. Lack of oral care prior to breakfast would not support the conclusion that the regulation had been violated. There was no documentation of what the teeth looked like at observation. As referenced above, Resident #2 was not included by the field surveyor, nor discussed at survey task six where the identified concerns are discussed by the field survey team. Review of worksheets did not indicate that Resident #2 had dirty feet at the time of the visit. There is no documentation in the facility's clinical record noting dirty feet on this resident six months prior to the visit at issue. Moreover, F312 was cited after supervisory review, and the severity of the F312 deficiency cited was not reduced, as P&A claims, in assigning the scope of this deficiency as a "D," rather that an "E."

In the case of the complaint investigation completed on 6/17/03, of the four (4) deficiencies cited by the Division, P&A took issue with the one (1) tag; namely F281. F281 relates to meeting professional standards of quality. The P&A report indicated the surveyor notes failed to note three times where staff did not follow physician's orders. One incident involved oxygen administration for Resident #1. Department review of nurses' notes indicate on 4/26/03 at 10:00 p.m. oxygen was administered to Resident # 1 at three liters instead of two liters and also on 4/27/03 as noted. In addition, the clinical record documented the administration of three liters on 5/11/03 at 11:00, 12:00, and 10:00 p.m., even though the field surveyor only documented the 12:00 p.m. time in the deficiency report. The field surveyor's note suggests that two administrations were missed; however, the records indicated that all three were administered at the times ordered. The severity of the written deficiency as cited was unaffected by omission of this resident example, which could not be included since the clinical records established administration of the oxygen.

P&A also claims that a physician order for comfort measures was not implemented. Department review indicates the physician order for comfort measures for Resident #1 was obtained by telephone on 6/4/03. The facility had not received the signed copy by the time of the investigation. Nursing homes routinely obtain telephone orders from physicians and subsequently send the original order to the physician for signature. In this case, not enough time had elapsed for the signed order to be returned to the facility. Absence of the signed order was not sufficient to conclude a regulatory violation, and the facility had followed proper procedures to get the telephone order signed by the physician.

The last example cited by P&A under F281 concerned an incident of a resident choking on a hotdog. However, the issue of the staff failure in notifying the physician of the actual choking was cited by the Division under tag F157. F157 is a physician notification tag and this issue was more appropriately cited under F157.

Nursing Home "B"

The P&A report includes review of complaint investigation #7112 conducted on January 14, 2003. This investigation resulted in two deficiencies, F314-D and F309-G and fining & citation #2130, which included a Class-1 citation and $2,500 fine.

F314 indicates the facility has a deficient practice in providing pressure sore care. The scope/severity rating of "D" is assigned, as the deficient practice only involved one of the five residents reviewed that had pressure sores, and the facility's deficient practice was one that had the potential to cause harm, if not corrected.

F309 indicates the facility has a deficient practice in resident assessment and intervention. This means the status of residents was not always appropriately evaluated and appropriate actions were not always taken. The scope/severity rating of "G" is assigned, as the deficient practice is based on review on one resident and harm to that resident occurred as result of the deficient practice. The harm also triggered the fining and citation.

The P&A report alleges that the final statement of deficiencies failed to report the field surveyor's review of Resident #2's record. The field surveyor's notes reflect that Resident #2 had an open area to left buttocks, that measured 2x4 cm, and had a flap of skin hanging on buttock. Additionally, the field notes indicated that there was a 12/31/02 order for treatment to the left buttock and documentation that the dressing was intact but soiled. The field surveyor also noted that the lounge smelled of urine.

These annotations are present, as indicated by P&A; however, there is significant additional documentation the P&A report does not address which reflects ongoing assessment and interventions for the resident. The field notes indicate that pressure relieving devices were in use on both the bed and chair, that sheep skin was being used, the position changes were to occur every two hours, that meals and snacks to be encouraged so as to promote healing, and that the physician ordered treatment to be administered. The notations identified by P&A do not, in and of themselves, indicate a deficient practice. Rather, the documentation has to be evaluated in context. This resident was not included in the deficiency and it is reasonable to conclude the surveyor determined the pressure sores were appropriately assessed and cared for.

There is also field surveyor documentation, as noted, that at 11:10 a.m. there was a smell of urine in the lounge. A one-time observation of a smell of urine does not create a citable regulatory violation. The trained field surveyor makes the notation when it is observed, and then continues monitoring to assure there was not a problem with urine odors from lack of incontinence care or other issues. One can conclude from the notes that monitoring continued and the annotation made at 3:55 p.m. indicates that the area was washed and new dressing applied. The absence of any other documentation would indicate that the urine odor was transient and incontinence care was being monitored and not identified as a problem.

The P&A report also indicates the Division Final Report failed to report 11 residents in the facility had skin problems. The surveyor requested a list from the facility of all residents with skin care issues, as would be appropriate when investigating a complaint related to pressure sores and assessment/ intervention issues. The facility did identify 11 residents with skin problems. The surveyor chose five of the residents that were identified as having pressure sores in their sample. The deficiency appropriately indicates the size of the sample of residents reviewed.

The P&A report also alleges the Division Final Report does not address Resident #4's hospitalization in November 2002 for open area on right buttock and right toe and the same Resident died 12/03 due to abscess resulting from negligent care. However, Resident #4 is cited by the Division in relation to the very serious problems with assessment intervention as found in the deficiency at F309. The Final Report does make reference to the pressure ulcer noted in the November 2002 Minimum Data Set (MDS). (The MDS is a federally mandated assessment tool.)

The P&A report also alleges the Division Final Report fails to report the field surveyor's review of Resident #6's MDS and its inaccuracy. It is also alleged the review of Resident #6's record did not identify that the "aide did not check for incontinence and the right side of the resident lay in urine, and

aide did not wash right hip." Field surveyor documentation reflects that Resident #6 is a closed record review. A closed record review means review of a record involving a resident who is no longer in the facility. There was no documentation related to "an aide not checking for incontinence care" and because this was a closed record review, the Resident could not be interviewed. There is field surveyor annotation that states, "MDS not accurate," however; additional investigation revealed documentation reflecting social worker assessment of behaviors and input of such into the MDS with an additional notation by the field surveyor of "has new MDS."

Although assumedly well intended in its attempt to review worksheet documentation in relation to the Division's "Final Report," these examples of critique by P&A are inaccurate. They serve to further illustrate a lack of understanding of the regulations, the survey protocols and process, and the evaluation of findings and documentation in relation to outcomes and inclusion in the Final Report.

Nursing Home "C"

P&A compared the Division findings of a complaint investigation completed 8/15/03 (regarding Complaints #689 and #755) and a survey completed on 8/22/03. P&A indicated concern that Complaint #755 was not substantiated by the Division for housekeeping concerns voiced by the complainant. During the complaint investigation, the field surveyor found no issue with respect to environmental cleanliness. Therefore, the complainant's issue was not substantiated. The facility was, however, issued a citation during the complaint investigation for failing to have staff remove their gloves after direct resident contact for which hand washing is indicated, F444. Approximately one week after the complaint investigation, the Division conducted the facility's annual survey and cited the facility for tag F444 again. P&A indicated the tag F444 issued during the annual survey was similar to the concerns voiced during the complaint investigation, and that Complaint #755 should have been substantiated. This claim by P&A shows a lack of understanding of the survey process, as the issues under F444 included staff failing to remove soiled gloves after resident contact, failing to wash hands after contact with feces, and failure to sanitize the area after cleaning up. The appropriate tag was F444 for this issue. If field surveyors took issue with cleanliness of the resident environment, this would have been cited under F465 or F253, not F444.

The P&A report also expressed concern that the field surveyor did not find any violations regarding misadministration of the medications Aricept and Seroquil. Regarding these medications, the physician ordered medications indicating they were to be administered QD (once daily). Such medications are typically administered during the AM. The field surveyor observed documentation on the Medication Administration Record (MAR) confirming the nurse's contact with the physician on these orders, and the physician approved the medications for "PM" administration. These medications were administrated in accordance with physician orders. Therefore, no misadministration occurred. Once again, P&A erred by lack of attention to detail.

Nursing Home "D"

The facility was cited with thirteen (13) deficiencies at the survey completed in April, 2003. P&A contends, based on its review of field surveyor worksheets, that seventeen (17) deficiencies should have been cited. P&A also cites other examples of Division oversight in citing deficiencies.

Resident #8 was referenced in the final deficiency statement (2567L) at F221 on the use of physical restraints for failure to have a physician order for use of a Merry Walker. However, P&A erroneously

contends that Resident #12 was also identified in the field surveyor notes to have a restraint. No such documentation could be found. Further review revealed that Resident #11, not Resident #12, was documented in the field surveyor notes regarding restraint use. This Resident used a Merry Walker, which is classified as a restraint, as it prevents the Resident from rising. The Merry Walker for Resident #11 was physician ordered, the initial need for the Merry Walker was properly assessed and care planned, and allowed the resident a greater degree of independence in mobility. Thus, neither Resident #11 nor #12 should have been cited in the Division's Final Report. The notes establishing that the field surveyors correctly applied survey protocol by noting concerns and then reviewing all records to ferret out whether there was a deficient practice associated with each resident. Again, P&A misses the mark. There was no regulatory violation that warranted inclusion of either resident in the final deficiency statement.

The P&A report concerning this facility also asserts that Resident #9 should have been cited at F246, "Quality of Care," for a positioning problem. F246 is a Quality of Life tag, not Quality of Care. This distinction is absolutely obvious to the trained eye, and illustrates the type of unfortunate error committed by P&A. Under CMS federal survey guidelines, a regulatory violation for positioning would be dependent on detailed analysis of several issues, and the result would dictate where the deficiency would be cited. For example, if the failure to reposition resulted in a pressure sore, the deficiency would be cited at F314, not F246. If failure to reposition the resident resulted in a decrease in range of motion, it would be cited at F318, and so on. Many residents of long-term care facilities lack the ability to reposition themselves and frequently make use of positioning devices. The absence of a positioning device does not, in and of itself, establish a deficiency. Review of field surveyor notes for Resident #9 indicates an absence of any observation of a positioning deficiency. There simply was no legal basis on which to cite a deficiency for Resident #9 under F246.

The P&A report also claims that a deficiency should have been cited at F252, because notes from the group interviewed indicate a resident was missing a TV remote for three months. This statement, in and of itself, does not rise to the level of a deficiency without further facts to indicate facility culpability. For example, the remote may have been hidden by a cognitively impaired resident, the remote could have been removed by the resident's family, the remote could have fallen into the trash and been discarded, etc. To further illustrate the fact that uncorroborated statements may not be sufficient to support a deficiency, the Division once investigated a Resident complaint that her Christmas chocolates were stolen. Upon investigation, it was determined that the chocolates were actually consumed by another resident who had authorized access to the room. In this case, the survey notes did not indicate whether the remote was still missing at the time of the survey, or if the facility had taken action to assist the resident in locating or replacing the missing item. There was no evidence in the file to substantiate facility failures, and P&A's criticism lacks merit.

The P&A report claims that a deficiency should have been cited at F254 because Residents #5 and #7 complained of problems opening windows in their rooms. Interviews indicated facility maintenance was actually dealing with the concern at that time. Facility self-initiated correction of a resident concern (of a remedial nature) does not support P&A's conclusion that a deficiency should be cited. The law is contrary to P&A's contention. In addition, P&A asserts that four of nine residents stated they had concerns with the facility temperatures. The actual documentation in surveyor notes stated: "4/9 residents at times had concerns with facility temperatures." Individual resident and family interviews did not identify a problem with temperatures, nor did field surveyors during onsite time note a temperature problem. Again, there was no evidence on which to base a sustainable deficiency. Further, none of these charges by P&A support the conclusion that Department supervisors are "removing findings."

The P&A report indicates that Residents #3 and #9 were identified with bruising per the surveyor notes, but were not cited at F309. Resident #9 had documentation of a bruise on the hand on 1/19/03. However, the presence of a bruise is not definitive as to whether the bruise resulted from a deficient practice. For example, if the Resident bruised himself or herself as the result of turning over in bed, the bruise would not result from a deficient practice committed by the facility. In addition, this resident was on several medications that could significantly impact the degree and likelihood of bruising. The Resident's wife was informed of this fact, as was the Advanced Registered Nurse Practitioner (ARNP), who ordered a protime (lab test to evaluate the ability of the blood to clot). The facility clinical records did not indicate a direct cause of the bruise, and the facility took appropriate action when the bruise was identified. The bruise on this Resident did not rise to the level of a sustainable regulatory violation. Resident #3 was also on several medications, which increase bruising; however, no documentation could be found in the surveyor's notes related to bruising.

The P&A report also asserts Resident #4 should have been included in the deficiency, cited at F312, for an oral hygiene issue. A review of the field surveyor's notes failed to identify any concerns with oral hygiene. Therefore, this reference, like others in the P&A report, appears to simply be erroneous.

The P&A report asserts that the Division's Final Report fails to mention deficiency/violation at F314, Pressure Sores. A review of surveyor notes for Residents #2 and #4 failed to show any documentation regarding pressure sores. Both of these Residents were identified as "at risk" for pressure sores in the MDS Assessment, and care planned appropriately by the facility. Neither Resident possessed a pressure sore. The facility cannot be cited for something that does not exist.

The P&A report indicates that the Department's Final Report fails to mention the deficiency/violation at F324, Falls, which is recorded in the field surveyor notes for Residents #1, #3, #11 and #14. Resident #1 had a goal on the care plan related to prevention of falls. That goal was met, as no falls had occurred. Although appropriately reviewed by the field surveyor under the umbrella of falls, there was nothing to cite, as the care plan goal had been met, and the resident did not fall. In addition, Resident #3 was identified as a fall risk with documented falls on 2/15/03, 3/28/03 and 4/5/03. Ongoing assessment was fulfilled regarding interventions for this Resident to receive a physical therapy evaluation and restorative care. Too, efforts to increase strength for safer transfers and ambulation were implemented. Again, the field surveyor appropriately reviewed this issue, and there was nothing to cite in the final report. These two examples vividly illustrate the reason that investigative notes identifying an area to be investigated by a field surveyor do not, in isolation, establish a deficiency to be cited. Rather, the field surveyor flags the issue and investigates it. Upon investigation, it may be concluded there was no violation for which to cite the facility. As to Resident #11, facility records indicate a fall while utilizing a Merry Walker on 2/2/03. The physician and family were notified of the fall. The Resident was reassessed and anti-tip devices were added to the Merry Walker to prevent future falls. The facility responded appropriately, and was not culpable for the fall sustained while using the protective device. Therefore, no citable regulatory violation existed. Lastly, there was no Resident #14 in the sample of residents reviewed. P&A's reference to a Resident #14 is in error.

The P&A report identifies a laundry list of concerns gleaned from field surveyor worksheets that were strictly observations. These observations do not rise to the level of a regulatory violation. In particular, the observations quoted in P&A's report, with comment, are as follows:

"Food was not being removed from trays in the dining room." There is no Federal or State regulation that mandates food be removed from trays in the dining room.

"Water was not being poured into glasses on some of the tables." Water pitchers were available on the tables and utilized by residents.

"Table #3 had no food on it." The field surveyor documented the chronology of observations in the dining room. The notes accurately reflect at 8:22 AM, Table #3 had no food on it; however, the very next documented observation at 8:25 AM stated residents at Table #3 had already been served. P&A's report omits reference to this observation that the Residents had already been served.

"An aide gave a resident a handful of medications he/she took with water." It is not a regulatory violation to give medications with water, unless they are specifically ordered to be given with food. There was no documented evidence that the medications were administered inappropriately. In fact, providing water for medication administration is in accord with professional standards.

"Observing a table was brown with food particles on edge." The table with food particles on the edge was observed during the breakfast meal. Food particles are a common occurrence, especially in facilities serving disabled persons who may be unsteady in the use of dining utensils. Since this observation was not again noted during the survey, and was resolved at subsequent meals observed, concern is minimized.

"A back nursing station having stale water." The field surveyor notes actually state: "water stale – 2 jugs." The notes do not indicate whether this was the only source of water at the back nursing station, or if residents actually had access to the water. There is not even any indication this was drinking water. Therefore, this notation by the field surveyor did not constitute a regulatory violation.

"A resident being left in the physical therapy room unattended." The field surveyor observed a resident left alone in the physical therapy room for nine minutes. At no time does this surveyor indicate an unsafe situation. Residents are frequently alone in their rooms for longer periods of time and may be safely left alone in other areas of the facility as well.

"Finding soiled wall outside PT room." The surveyor observed a soiled wall in a hallway. This observation was not repeated during the survey and would not constitute a regulatory violation.

"A resident being administered a blood sugar test with another resident in the room where the curtain was not pulled for privacy." This observation does not constitute a deficiency. The blood sugar test was a finger stick, so it did not require any exposure and did not constitute an invasion of privacy. Moreover, from the surveyor's documentation, there was no indication the roommate could visualize or perceive the procedure.

The P&A Report erroneously indicates that, using the "Three Tag Review Form," the Program Coordinators changed the scope and severity letter from a "G" to an "E" for F309. The Division does not utilize a "Three Tag Review Form." Rather, the Division uses a "Performance Standard Three – Tag Review Form." More important, however, no change in scope and severity occurred because, as previously noted, field surveyors lack authority to assign scope and severity. The scope and severity assigned to tag F309 could not be a "G," and had to be an "E." The scope and severity assigned to this deficiency was a decision made by the Program Coordinator, the Bureau Chief and the Compliance Officer. A "G" scope and severity could not be assigned because the facts did not establish that a Level 3 deficiency, as defined in the State Operations Manual, Appendix P, had occurred. The SOM definition provides that a "Level 3 is noncompliance that results in a negative outcome that has compromised the Resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial

well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident."

The P&A report also asserts that, using the "Three Tag Review Form," the Program Coordinators have changed the scope without giving an explanation for the change. In reality, as noted above, there was no "change," since only the supervisor can assign scope and severity. Moreover, this statement by P&A illustrates a lack of understanding as to the term "scope." Scope and severity ratings are assigned in accordance with a federal grid. "Scope" refers to how widespread the problem is. There are three tiers on the grid relative to scope; namely, isolated, pattern or widespread. These are assigned under numeric requirements based upon the number of residents involved. "Severity" refers to whether the deficiency resulted in a level of harm or not. Severity assignments are also tiered and range from no actual harm with potential for minimal harm to immediate jeopardy to resident health or safety. The scope and severity rating cannot be assigned in the field. Once assigned, certain remedies (i.e., penalties such as denial of payment for new admissions, the assessment of a federal civil money penalty, termination of the provider agreement, etc.) may then be imposed. The findings as reported still demonstrated a "pattern;" however, the findings did not rise to a Level 2 that would indicate more than minimal harm could occur. A "B" level deficiency still requires the facility to submit a plan of correction.

The P&A report erroneously indicates that on the "Three Tag Review Form" the Program Coordinators have changed the scope and severity letter from an "E" to a "C." In actuality, the scope was actually elevated from a pattern to widespread; however, the findings did not rise to a Level 2, which would indicate more than minimal harm could occur. A "C" level deficiency still requires the facility to submit a plan of correction.

Nursing Facility "E"

The P&A report includes review of complaint investigation #93 conducted on March 26, 2003. The report also includes review of a survey conducted September 24-27, 2002.

Complaint #93 alleged two problem areas, resident dignity and dietary sanitation. The investigation did not identify any deficient practices. The P&A report does not make any claims of inadequate reporting following their review of this complaint investigation.

The survey resulted in three deficient practices being identified in the final statement of deficiencies, namely F312, F323, and F432.

F312 indicates the facility had a deficient practice in personal hygiene to residents. The scope/severity rating of "D" is assigned, as the deficient practice involved three residents and the facility's deficient practice was one that had the potential to cause harm if not corrected.

F323 indicates the facility had a deficient practice in assuring the general environment was kept free of accident hazards. The scope/severity rating of "E" is assigned, as the deficient practice was identified more than three times but was not found to have occurred throughout the entire facility, and the deficient practice was one that had the potential to cause harm if not corrected.

F432 indicates the facility had a deficient practice in assuring that only appropriate staff had access to resident medication. The scope/severity rating of "C" is assigned, as the deficient practice was

identified to be widespread (all staff had access to the refrigerator where meds were stored), and the deficient practice was one that had minimal potential to cause harm if not corrected.

The concerns identified in the P&A report relate to its review of field surveyor documentation related to Residents #1, #5, #6, #7, #8, and #11. The P&A report alleges failure by the Division to include in the statement of deficiencies information from the field surveyor notes that P&A believes equates to a negative finding/deficient practice.

Resident #1:
P&A review of field surveyor notes related to Resident #1 identified annotations reflecting that this Resident was placed in the nursing home due to a broken hip 02/02 and on 9/09/02 the Resident was found on the floor with his/her body alarm on the bed. This annotation was contained in worksheets. P&A fails to also report that the field surveyor notes reflect that the Resident took his/her body alarm off, and the doctor and son were so notified. Additionally, other notations indicate the Resident was assessed as a fall risk, was being monitored for such with care plan interventions of body alarm, low electric bed and skid strips, and was receiving rehab ambulation five times per week. In and of itself, P&A's isolated chosen notation does not amount to a Division failure to report a negative finding/deficient practice.

P&A review of field surveyor notes related to Resident #1 also identified annotations reflecting that the Resident fell at dinner on 9/23/02. Review of records did not specifically identify this finding. However, there is an annotation that states, "resident fell at dinner." This annotation comes from field surveyor notes recording review of a History & Physical dated 1/23/02, not 9/23/02, and it referenced the Resident's prior history, not current findings. The notation on the history and physical is not evidence of a violation in September, 2002.

P&A review of field surveyor notes related to Resident #1 also identified annotations reflecting weight loss from January and August. This is accurately documented, but fails to include all of the other related references to weight loss. The field surveyor's notes also reflect that the Resident had depression and cognitive impairment, putting him/her at risk for weight loss. The facility was monitoring and assessing the Resident's weight loss, developed interventions, and monitoring labs. There is no indication that family and doctor were unaware of the entire situation or that the field surveyor observed the facility as deficient in addressing the situation.

Resident #5:
P&A review of field surveyor notes related to Resident #5 identified annotations reflecting the Resident fell on 9/04/02, and on 8/7/02 the Resident was found on the floor with a bump at the side of his/her head and a skin tear. The doctor was notified. This annotation was contained in field surveyor notations on worksheets. P&A fails to also report other annotations indicating assessment as a fall risk due to dementia and unsteady gait, monitoring for such with appropriate care plan interventions of body alarm, low bed and bumper mattress pad. Again, in and of itself, P&A's isolated chosen notation does not amount to a Division failure to report a negative finding/deficient practice.

P&A review of field surveyor notes related to Resident #5 identified annotations reflecting that on 8/25/02 the Resident was "not ambulating like normal, leaning to left, lump diminished, transferred to ER for evaluation. Returned 8/26/02 with pneumonia." This annotation is, in part, accurate. The reference to "lump" should read "lungs." Other documentation not cited by P&A reflects the Resident was assessed, transferred to the hospital, and treated. Once again, in and of itself, P&A's isolated

chosen notation does not amount to a Division failure to report a negative finding/deficient practice. The field surveyor notes actually reflect a condition change that was appropriately acted on by the facility.

P&A review of field surveyor notes related to Resident #5 identified annotations reflecting that on 8/31/02, the Resident was noted to have a "dark purple bruising on left outer thigh, hip and tail bone area." This annotation was contained in worksheets. Once again, P&A fails to report other corresponding annotations indicating this Resident was appropriately assessed to be at risk for bruising, due to prescription medications, dementia, and an unsteady gait. This specific area was assessed and reported to the physician. The notation of bruising for this resident does not establish a regulatory violation, nor does it demonstrate the Division failure to report a negative finding/deficient practice. The surveyor notes actually reflect a condition appropriately acted on by the facility.

P&A review of field surveyor notes related to Resident #5 also identified annotations reflecting that on 9/02/02, the Resident was found sitting on the floor with no pants on and only socks on his/her feet. A skin tear was noted on left hand, wrist and elbow and an abrasion was present on the knee. This annotation was contained in worksheets, but again P&A fails to also report other corresponding annotations indicating the Resident was appropriately assessed as a fall risk, as noted above. Again, the Resident was being monitored with care plan interventions of body alarm, sonar alarm, low bed and bumper mattress pad. Furthermore, the record also indicates the Resident unpinned the body alarm and both the doctor and son were notified of this fact. The field surveyor notes reflect an ongoing situation where this Resident, in spite of impaired condition and desire to act independent of staff assistance, was being monitored and interventions were in place to allow some independence, yet keep the Resident as safe as possible. A field surveyor makes notations as records are reviewed. Notation from the clinical record is not the automatic equivalent of a deficient practice. To repeat, the totality of circumstances must be evaluated. Not all of the notations are reflective of deficient practice. Rather, the cumulative notations represent information the field surveyor believes may be pertinent in making the collective assessment of deficient practice. P&A misapprehends the regulatory scheme and protocols.

P&A review of field surveyor notes related to Resident #5 identified annotations reflecting that on 9/03/02, documentation identified "multiple bruises -- wheelchair tipped." The annotation of multiple bruises does exist on 9/3/02, but does not state any connection to wheelchair tipping. Once again, P&A fails to note or report other annotations indicating appropriate assessment and physician notification. Bruising for this Resident would not be a sufficient fact on which to support a deficiency. Physician notification along with labs and medication adjustments are ignored by P&A.

Resident #6:
P&A review of field surveyor notes related to Resident #6 identified annotations reflecting a strong urine odor in the room of Resident #6.

This is correct, as reported by P&A. However, as the rest of the relevant information omitted by P&A reveals, additional notation reflects that the field surveyor had monitored this same Resident at 7:53 AM, 8:19 AM, 8:45 AM, 9:45 AM and 9:52 AM. All observations were made while in the dining room, and there is no mention of odor or apparent incontinence. Only at the 9:45 AM observation, when the Resident was in his/her room, was a strong urine odor identified. The field surveyor documents that the Director of Nursing was informed, and indications were that the odor was from Resident #6's roommate. Further notation at 9:52 AM indicates one nurse aide was present with the Resident offering fluid while waiting for another nurse aide to assist with cares. Contrary to P&A's suggestion, an isolated urine

smell associated with recent incontinence by this Resident's roommate does not reflect a citable deficient practice.

Resident #7:
P&A review of field surveyor notes related to Resident #7 identified annotations reflecting "F323: Resident fell on 8/25/02 (mat by bed)." This annotation is correct. However, P&A repeatedly fails to report other documentation. In this case, charting shows that the Resident was on the floor in front of his/her wheelchair and reported landing on his/her buttocks. Also, no injury was noted after assessment, and the physician and family were appropriately notified. This Resident attempts independent mobility, which is his/her right. In attempt to maintain independence, but also prevent risk of injury, the facility used a low bed, bumper mattress and floor mats. The Resident also received assisted ambulation exercise five times per week and was encouraged to attend exercise class. P&A ignores the entirety of the record. By doing so, P&A erroneously suggests Division errors or misconduct.

P&A review of field surveyor notes related to Resident #7 identified annotations reflecting the aide "didn't wash [a] thigh and applied Elta Seal (sp?) with same gloves as used to wash buttocks."

This observation was present in the field surveyor's notes. However, as an isolated finding in the absence of any other infection control issues or negative care outcomes, it would not be properly cited as a violation. Furthermore, additional documentation by the field surveyor indicates the resident's skin was clear with no redness noted. The field surveyor's notes also reflect the gloves were subsequently changed. Once again, P&A has missed the mark.

Resident #8:
P&A review of field surveyor notes related to Resident #8 identified annotations reflecting that oral care was not provided and the right thigh was not cleaned. Additionally, this Resident had a 12% weight loss.

The notation regarding the Resident's oral care not being provided during morning cares was accurately cited. However, this would not, in isolation, constitute a deficiency. Additionally, P&A's reference to "12 percent weight loss" was taken out of context. The field surveyor notes identify the 12% weight loss from review of the resident's initial nutritional assessment, which occurred 4/3/99. The Resident's 12% weight loss preceded admission. Clinical records indicate that the Resident did not sustain a significant weight loss while in the facility. Like so many others, this example by P&A does not demonstrate a Division failure to report a negative finding/deficient practice.

Resident #11
P&A review of field surveyor notes related to Resident #11 identified annotations reflecting a fall on 6/2/02 resulting in a fracture of the fifth metacarpal and the Resident not being taken to the hospital until the next day. Additionally, it is identified that on 9/22/02, this resident was admitted to the hospital with renal failure. According to the hospital records, the Resident had flu-like symptoms for over three weeks and increasing weakness, when they were released to hospice. These annotations exist, but P&A falls short of telling the full story. For example, the resident was found on the floor by the nurses' station while walking with family, unassisted, after attending a potluck. Facility documentation reflects that the Resident complained about his/her hand hurting and said they thought it was broke. Swelling was noted at fourth and fifth knuckle, but the Resident was able to straighten and flex. The doctor was notified, ice was ordered and the doctor informed staff to call the next day if there was no improvement. The family was aware of the situation. The doctor was called the following morning with a report, and

the Resident was then taken to the hospital. This is not a failure to report a negative finding/deficient practice, as the family was with the Resident and aware the Resident was ambulating independently. Additionally, the Resident was assessed, the doctor was notified, and the family was kept informed.

The annotation regarding this Resident being admitted to the hospital on 9/22/02 with renal failure is also accurate. Notations also indicate, however, that the Resident went out on pass with his/her family on 9/19/02. On 9/21/02, the Resident complained of not feeling well. Worksheets reflect ongoing assessment, report to the doctor, timely transfer to the hospital with subsequent admission, diagnosis of renal failure, and transfer to hospice on 9/22/02. The Resident expired on 9/24/02. The field surveyor did not identify deficient practice on the part of the facility reflecting inadequate assessment or intervention contributing to renal failure.

Nursing Home "F"

The facility was cited with thirteen (13) deficiencies at the survey completed in June, 2003. P&A contends, based upon its review of field surveyor worksheets, that at least twenty (20) deficiencies should have been cited. Applying appropriate legal and regulatory analysis shows this contention is in error.

The P&A report contends that F309 failed to mention Resident #6 sustaining dark purple bruising on the right side of her breast and a skin tear on her finger. A careful review of F309 reveals that the entire deficiency addresses lack of assessment and intervention for Resident #6 relating to his/her leg fracture and subsequent development of open skin lesions (as a result of a brace used to stabilize the fracture). The issues cited in the Division's report occurred in May and June of 2003. The bruise referenced in the P&A report was actually identified in December, 2002, shortly after the Resident's admission to the facility. It was not factually related to the cited deficiency. The records do not establish the presence of a deficient practice associated with this bruise. The skin tear was identified in February, 2003. It, too, was not factually related to the cited deficiency. Inclusion of those notations from the clinical record would not have supported the final findings and would not have changed the scope and severity of the deficiency, as it was cited at a "G" harm level. The facility also received a Class II $500 state fine for the failure to assess Resident #6 appropriately.

The P&A report also raises an issue challenging the Division about Resident #9, identified with a mouth sore, an example P&A claims was not included in the examples at F309. This Resident was, in fact, included in the original report. However, on appeal by the facility, an Informal Dispute Resolution Conference held by an independent reviewer (August 15, 2003) resulted in deletion of this example. Importantly, deletion of this isolated example did not change either the scope or severity on the Form CMS-2567L, or the class and amount of the state fine issued and sustained in this case. This is yet another example in the P&A report illustrating an absence of fundamental knowledge and understanding of the process.

The P&A report also questions why Resident #2, identified in the surveyor notes with abdominal pain, was not included in the examples at F309. Resident #2 was not included because the record demonstrates the facility appropriately assessed and treated the symptoms of abdominal pain.

The P&A report references Resident #22 being sent to the hospital for a wound infection on 6/4/03. The Resident was sent to the hospital on this date, but he/she was not sent due to a wound infection. Rather, the Resident was sent to the hospital as the result of a fall. Consequently, the incident was cited at F324

at a "J" (meaning immediate jeopardy to resident health or safety), and the facility was issued a Class I, $4,500 state fine by the Division.

The P&A report asserts that Resident #11 should have been included in the deficiency at F327, Hydration. The field surveyor notes indicate that at 7:16 AM, the Resident had an empty water pitcher and no glass by his/her bedside. However, the notes also indicate that this Resident went to breakfast at approximately 7:56 AM, where fluids were available for immediate consumption. This Resident was, in fact, provided with fluids. Additionally, there was no indication that the Resident was not adequately hydrated.

The P&A report lists several concerns it inferred from field surveyor worksheets that are, in reality, simple observations not rising to the level of a regulatory violation. The field observations quoted in the P&A report, and the Department's response, are as follows:

"Turkey loaf done at 10:45 for 11:45 service – overdone." The "overdone" turkey loaf notation was based upon the internal temperature monitored by the Division's dietitian that exceeded the done stage. There was no accompanying indication that this food product was not palatable, or that residents did not eat it.

"Pan of sandwiches in refrigerator, not dated." The undated pan of sandwiches in the refrigerator was actually served at the evening meal. Regulations provide that food prepared and served the same day does not require dating.

"Not using gloves between residents' trays when putting food on trays." All items being handled were considered "clean." Under existing guidelines, there would be no need to change gloves unless a "dirty" item was being handled.

"Must heat for long period of time because no steam equipment for fast reheating and cooking." There is no existing requirement to have steam equipment for fast reheating. Guidelines specify that reheating must be done to a maximum temperature, but no time frame for that reheating is defined.

The P&A report references two residents, #11 and #16, with documentation of restraint use on the field surveyor's worksheets. However, the P&A report neglects other related facts. Resident #11's clinical record contained extensive documentation regarding the facility's use of devices to prevent falls such as lap trays, seat belts and sit/stand alarms. The Resident had also been evaluated by occupational therapy (OT) to find the least restrictive type of device that would still allow the resident as much independence as possible. The facility also had a physician's order for a seatbelt based on the OT assessment. The use of the seatbelt had been care planned, and the family had been educated on restraint use. The protective devices used for this Resident did not constitute a restraint use violation, and the field surveyor appropriately flagged and investigated the issue. Resident #16 was utilizing a seatbelt restraint that was properly ordered, assessed and care planned. Both use and assessment of the seatbelt were verified by the clinical record and reviewed by the field surveyor. The P&A report erroneously references "no charting" in March and May 2003 regarding the seatbelt, and suggests that this alleged omission constitutes a violation not cited by the Division. P&A must be unaware of the fact that charting on the ordered seatbelt was not required, and that federal regulations actually require quarterly assessments on the MDS. These quarterly assessments were present in the record and verified.

The P&A report references Resident #13 being "found on [the] floor 4/29/03, admitted to [the] hospital on 5/2/03 for [a] pressure ulcer, [and] readmitted on 6/25/03." From this reference, P&A suggests facility noncompliance not cited by the Division. The clinical record actually reveals that the resident was found in the bathroom, sitting on the wheelchair pedals on 4/29/03. The Resident was promptly sent to the hospital due to increased confusion, returning to the facility on 5/2/03 with a small pressure sore noted on the coccyx. The pressure sore was then evaluated and treated by an enterostomal therapy (ET) nurse. The Resident compromised treatment of the area by frequent noncompliance with timeframes specified for sitting up. This increased pressure to the area and interfered with healing. No citable regulatory violation occurred in the care of this Resident.

The P&A report references Resident #5, who was admitted to the facility with a left ankle ulcer and open areas on the left hip and coccyx area. By so noting, P&A suggests that the Division was remiss in not citing this Resident as an example of a deficiency. The presence of pressure sores at the time of admission do not support a conclusion that the facility's action or inaction caused the sores. Indeed, the sores predated the facility's treatment of the Resident. The field surveyor noted: "MD progress note 5/23, 6/12 – wound not addressed." They then verified that the facility did assess the Resident's wounds on a routine basis. The physician who authored the record did not include any documentation regarding the wounds in the progress notes. The regulations do not dictate to the treating profession any content for the progress note. The physician exercises independent professional judgment in his/her completion of progress notes. Additionally, the 5/23/03 MD progress note stated: "Looks depressed – psych consult." The Resident was promptly seen by a psychiatrist who prescribed Prozac for the depression. No regulatory violation occurred with regard to the treatment of this Resident.

The P&A report indicates that Resident #17 was documented in field surveyor notes as needing an MDS, suggesting the Division ignored this fact. This MDS issue was, in fact, cited at F272 as an "A" level observation. In addition, P&A reports that the field surveyor notes indicate no dietary intake was kept for 6/3/03, again suggesting failure to cite by the Division. The Resident was receiving enteral feedings through a J-tube and oral fluids, as tolerated, as a supplement. There is no indication in the records that the physician had even ordered intake and output to be recorded. The absence of documentation for oral intake on one day simply does not constitute a regulatory violation.

The P&A report accuses the Division of omissions when citing F273 and F280. These accusations are based on notes from surveyor worksheets. The notes, and the department's response, are as follows:

Resident #18:
The "6/26 care plan & MDS not done per staff, no part of it done." This was, in fact, appropriately cited by the Division at F273 as an "A" level finding.

Resident #23:
"Surveyor notes identify as having trauma from being on a bedpan for an extended period of time. (4/29/03)" The field surveyor notes do not include the phrase: "for an extended period of time." P&A's attribution to the field surveyor is in error. The field surveyor's note actually states: "trauma from being on a bedpan." This resulted in a small skin lesion on the posterior thigh. The actual field surveyor notation does not establish that the facility violated a federal or state standard. This Resident was no longer in the facility and could not be interviewed about the event.

Resident #25:
"Surveyor notes identify as not having gotten a shower for two weeks – was also given another resident's inhaler." The issue relating to the Resident missing showers was due to his/her dialysis schedule resulting in extended times away from the facility. The problem was identified and corrected by the facility prior to the survey. The issue concerning the inhaler did not involve a medication error, as it was the same inhalant ordered. In addition, no infection control issues were identified, as the inhaler had not been used by the other resident before it was used by Resident #25. These isolated notations by the surveyor raised issues that were reviewed during the survey, do not constitute evidence of a violation, and do not reflect Division neglect, inadvertence or oversight.

Resident #26:
"On 6/27/03, the surveyor spoke with an employee and confirmed that an assessment was made on 3/14/03 at 3:30 AM regarding congestion. There was no further assessment until 11:30 AM on 3/15/03 when the Resident fell, sustained a head injury, had emesis and was sent to the hospital by ambulance per doctor's order." The employee interviewed "verified that the nurse involved in the incident did not complete an assessment of the Resident's condition prior to the fall, nor of his/her respiratory status." There is no indication in the clinical record that a further respiratory assessment was warranted. Appropriate assessment and intervention was conducted following the Resident's fall, with a transfer to the hospital. This was a closed record, making follow-up to validate the information with the Resident and/or family very difficult. The statement of the facility employee, without actual evidence of causation, or something more, would not support the conclusion that a rule had been violated.

The P&A report also indicates that the Group Interview conducted by the field surveyor identified many missing items. P&A suggests that this should have been cited by the Division as a deficiency. The group interviewed lacked any specificity as to the missing items. The notes did not identify when items were noted to be missing, i.e.: one week ago, one year ago, etc. The notes did not indicate whether family may have taken the items, and the notes did not contain important first-hand information. Additionally, there was no mention in the notes regarding facility interventions to locate or replace the missing items. Without significantly more information, these statements simply do not rise to the level of a citable regulatory violation, and would not be sustainable, if cited.

The P&A report alleges that a deficiency should have been cited at F164, Privacy and Confidentiality, based upon a statement from Resident #3 regarding privacy when taking a shower. The interview does not indicate who walked in, and the presence of another person in the room was just as likely to be the result of staff lending aid to Resident #3, who required extensive assistance with bathing. Temporary staff from staffing agencies is frequently used to ensure staffing needs are met, and the Resident would not always recognize this. Staff presence during bathing and showering would not present a privacy issue. Perhaps of greater importance, no other residents in either group or individual interviews voiced a concern regarding privacy.

The P&A report alleges that a deficiency should have been cited at F168, as no one at the group interview knew where telephone numbers for agencies acting as client advocates had been posted. There is no indication that any of the residents desired to make a contact or that they could not locate this information. Neither is there information that, if requested, the facility would not assist. F168 states that residents must be afforded the opportunity to contact these agencies. There is no indication this regulation was violated. Again, this would not be a sustainable citation, if issued.

The P&A report alleges that a deficiency should have been cited at F223 because residents commented that the nursing home was always short staffed. The issue of a facility being "short staffed" would not be cited at F223, but, rather, at F353 and/or F354. This citation can only issue if field surveyors are able to substantiate the allegation using applicable regulatory standards. Staffing is always reviewed during an annual survey, and it is appropriately cited when the needs of the residents are not being met. In this case, facility personnel records do not substantiate a complaint that the facility was short staffed.

The P&A report alleges that a deficiency should have been cited at F492 because an employee worked as a CNA for approximately one year who was not qualified to pass medications. This staff person had actually completed a Medication Managers course. However, the CNA's certification had expired. Nonetheless, there was no evidence that this person was not competent to perform the task assigned and, most importantly, when the facility identified the expired certificate, it reassigned the individual to other duties. Furthermore, medication administration records were reviewed during the survey, and no irregularities were detected. In addition, there is no indication that any medication errors occurred due to the practice. If issued, a citation could not be sustained based upon these facts.

The P&A report also identifies and isolates "Random Observations" made by field surveyors that were documented on their worksheets, presumably asserting these Random Observations warranted citation by the Division. They do not. For instance, P&A notes the top two drawers of a treatment cart were open in the hallway, with two residents in proximity. P&A fails to note that the drawers contained creams for external use, which would not likely cause a problem. There is no indication the residents viewed in the proximity would or could open the drawers or remove any products. There is no indication concerning the time that the cart was unlocked or unobserved by any facility staff. This field surveyor random observation, in and of itself, does not rise to the level of a regulatory violation. Rather, the notation simply constitutes a flag to the field surveyor for possible in-depth review.

The P&A report alleges that several facility infractions related to Resident #28, including call light response resulting in disciplinary action of a nurse. A review of the files' worksheets failed to produce any supporting documentation regarding Resident #28.

The P&A report alleges that Resident #2's window was left open one evening in April or May, and the wind blew over a plant stand. The family indicated that at 6:00 AM, staff closed the window and cleaned up the mess. This action taken by the facility staff appears appropriate, given that no specific date for the occurrence could be isolated or additional information gathered. Field surveyors were not able to interview staff who may have been able to confirm the circumstances under which the window was left open. The mere act of leaving the window open does not constitute a rule violation, and would not warrant a citation.

The P&A report identifies Resident #3 to have stated that he/she wait for a toileting call light response is frequently excessive (forty-five (45) minutes). This concern relating to resident care could not be validated by either observation or other resident or family interviews. Again, these facts do not make for a sustainable citation.

The P&A report identifies that Resident #21 had no charting in the nurses notes for January or February. The field surveyor noted this during a review of the Resident's clinical record. There is no federal or state regulation that specifies the frequency for charting. Many facilities utilize "charting by exception" documentation in the clinical record, and will chart only noted concerns or problems. The absence of charting does not support a conclusion that a governing standard has been violated. In addition, there

was no indication in the clinical record that a problem occurred during January or February that should have been documented in nurse's notes. Once again, a citation in this regard could not be sustained.

In sum, this detailed accounting of P&A's analysis confirms that P&A's cursory review was just that. P&A's omissions of relevant facts and misapplication of regulatory requirements clearly demonstrates a lack of understanding of the federally prescribed process.

Proactive Initiatives:

In the past years, the Department has proactively taken steps to enhance regulatory activity and oversight. In September 2003, the Department hired a full time General Counsel. Prior to taking this initiative, the Department, like most other Executive Branch agencies, relied on the Iowa Attorney General's Office to provide an assigned attorney. While this arrangement is satisfactory in most situations, the Department's detailed regulatory responsibilities truly mandated "in-house" counsel, unencumbered by other agency representation. The attorney hired to fill the position was the Department's formerly assigned Assistant Attorney General who possessed vast experience in health care regulation. This position is on ready call to assist Division staff, provide training, and handle contested case hearings. The tightening of the Division's operations with this initiative has provided positive trends identified in this review.

Recognizing that the federal government continued to place more regulatory demands on the Division's oversight responsibilities, in December 2003, the Department initiated discussions with CMS to adjust the state match rate for survey and certification expenditures. Most of the Division's work is funded, at some level, by federal dollars. In March 2004, CMS agreed to adjust the state match rate effective retroactively to October 1, 2003. The funding generated by this adjustment stretched limited state funding and permitted the Department to seek, and receive approval, to hire five dedicated complaint investigation surveyors. Existing, experienced staff has filled these positions. Once the vacancies created by these transfers are filled, the Division will have 74 surveyors. Concerted efforts to backfill the vacant positions are on-going.

Dedicating experienced surveyor staff to only conduct complaint investigations has at least three positive benefits. First, since complaint investigations are time sensitive and the results can potentially immediately impact the health, safety and welfare of nursing home residents, having dedicated staff will ensure an effective regulatory presence. Second, the expertise gained from specialization in complaint processing will undoubtedly have a positive impact on consistent oversight. Third, staff responsible for conducting annual surveys will not often be called upon to also conduct complaint investigations. This should benefit the Division's ability to become more unpredictable in the frequency/timing of its surveys, as the Division will be better able to ensure a consistent presence dedicated to this regulatory mandate.

Additional proactive initiatives have been instituted to enhance regulatory oversight and consistency. For example, in September 2002, the central office Complaint Unit was increased to three experienced surveyors, federally SMQT trained. Recently, decisions were made to reclassify two positions to assist in complaint intake, oversight and consistency. One position will become a coordinating point between the Complaint Unit, complaint surveyors, the Investigation Division's dependent adult abuse investigator, and the Department's General Counsel. In addition, to ensure precise tracking of cases and consistent application of regulatory standards, this position will also assist in "prosecuting" administratively the heavy informal dispute resolution and contested case hearing workload. As of this writing, the Department's General Counsel is handling over 70 contested case hearings. Another

position is being reclassified within the Investigation Division from "field auditor" to "investigator." This position will be assigned to the Medicaid Fraud Control Unit and will investigate both provider fraud and dependent adult abuse referrals made from the Health Facilities Division.

Other proactive initiatives have contributed to the solid performance ratings the Division has garnered from the multi-tiered evaluation process conducted by CMS. For example, generating the "Top 16" list of most troubling nursing facilities, and maintaining a prominent presence in them, has honed the Division's priorities and reduced serious violations at these facilities. When confronted with a near doubling of complaints, the Division reached out to retired surveyors to assist with complaint investigations. Use of experienced and SMQT trained surveyors allowed existing staff to conduct timely annual surveys, with improved ability to be unpredictabile in scheduling. Website enhancements and database conversion from outside contractors to a sister state agency's Information Technology Enterprise was activated a week ago. Having "in-house" data warehousing will enhance the Division's ability to be responsive to regulatory changes, and save the State money. Finally, although unsuccessful to date, the Department continues to pursue legislative initiatives to strengthen regulatory enforcement.

All of these initiatives have and will enhance the Division's already solid regulatory track record.

Summary:

The Health Facilities Division of the Iowa Department of Inspections and Appeals cannot simply adopt potential violations identified by field survey staff, or use isolated field surveyor notes out of context to cite violations. Division central office staff take their federally mandated regulatory charge to conduct supervisory reviews very seriously. It is important that potential violations identified by typically less experienced field survey staff will be closely scrutinized by more experienced supervisors. P&A presented an incomplete and misleading analysis of field surveyor data without consulting with the Department to gain an understanding of the process and decisions made. The media relied upon P&A's report to its detriment, and the public has been left with the wrong impression.

The Division meets and exceeds federal performance standards, as confirmed by CMS' annual review of performance, comparative surveys and Federal Oversight/Support Surveys. The statistics presented in this response demonstrate that Iowa's state survey agency is doing its job very well. Selective reporting undermines the credibility of those who criticize the process. The proactive initiatives taken by the Department clearly indicate a recognition by the Division that its performance can always be self-examined and improved upon. These initiatives, and others, will further enhance the outcomes Iowans expect in nursing home enforcement – consistency, firm but fair application of the process, and, finally, a professional and knowledgeable state survey staff. The Department will continue to meet and exceed this expectation.

Upon review of the Department's response, I would be most interested in your views and I am available to meet at your earliest convenience.

Sincerely,

Steve Young

STEVEN K. YOUNG
Director

Enclosures

Nursing home regulators accused
By CLARK KAUFFMAN
REGISTER STAFF WRITER

July 9, 2004

A federal agency is accusing Iowa nursing home regulators of whitewashing inspectors' reports by downgrading violations that would otherwise result in stiffer penalties against the homes.

The allegations are made in a new report from Iowa Protection and Advocacy, a federally chartered organization that advocates for mentally ill and disabled people. The report, which is expected to be made public today, marks the third time in recent years that a federal agency has accused the Department of Inspections and Appeals of downgrading health and safety violations found in nursing homes.

"The public has a right to demand accurate and honest reporting," the report says. "Incomplete final reports are not only misleading, but can give the public a false sense of security."

The agency based its findings on what it acknowledges was a "cursory analysis" of 3,000 state records related to inspections at six Iowa nursing homes. The documents included the handwritten notes of the on-site inspectors, as well as the final inspection reports published on the Department of Inspections and Appeals Web site.

In theory, the published inspection reports represent the actual findings of on-site inspectors. However, the advocacy group argues that state administrators are sanitizing some inspectors' reports by deleting or downgrading certain violations before the reports are made public. The federal agency suggests that state regulators are making those changes to "reflect a false hope or improvement" in the care that's being delivered in Iowa homes.
Inspections and Appeals spokesman David Werning said his agency would not comment "on any claimed report of alleged findings."

He said inspectors' reports routinely face "quality-compliance reviews" that are required by law. "To suggest that the mandated quality review undermines aggressive regulation demonstrates a lack of understanding of the process," he said.

The federal agency's report describes one instance in which a state inspector faulted a home for the loss or theft of residents' belongings and the failure to prevent bedsores. According to the report, state program coordinators deleted the bedsore violations because the inspector hadn't documented the size of those sores. The final report also made no mention of missing clothing, money and charge cards belonging to residents.

At another home, the state's published inspection report made no mention of an inspector's findings that related to unanswered call lights, inadequate staffing, missing property, improper food preparation and the alleged distribution of medicine by an uncertified aide.

Iowa Protection and Advocacy is not the only agency to allege that state administrators are downgrading the violations found by inspectors.

In March 2003 , the Office of Inspector General in the U.S. Department of Health and Human Services issued a report that said Iowa was leading the nation in the number of alleged nursing home violations that state administrators either downgraded or deleted from the final inspection reports released to the public. According to that report, 25 percent of all alleged nursing home violations were downgraded in Iowa. Most other states reported rates of 1 percent to 10 percent.

Last summer, the federal General Accounting Office issued a report that said final inspection reports issued by several states routinely understated the seriousness of problems.

The inspector general's report was based on a written survey filled out by a state official. Werning said the official misunderstood a question on the form.

Werning said the GAO finding also was the result of a misunderstanding. The GAO, he said, was "Monday-morning quarterbacking" and making its own assumptions as to what sort of violations were deserving of the more serious citations.

A Des Moines Register review of state records related to unemployment benefits indicates that even in cases in which nursing home administrators or accused workers acknowledge abuse or neglect, the state might not act.

For example:

• State records indicate that Ashley DeGroot and Amber Scholten were fired in April from Pleasant Acres Care Center in Hull where they worked as caregivers. A co-worker and a resident reported seeing DeGroot deliberately spray a chemical shoe deodorizer in the face of an elderly woman who was trying to sleep. The co-worker gave a written statement in which she said DeGroot had boasted of targeting the woman for harassment. "I just like to piss her off," DeGroot allegedly said.

During the home's investigation into that incident, other residents and workers complained that DeGroot and Scholten were often neglectful, physically rough or verbally abusive to certain residents.

The home itself notified police and state inspectors and fired both workers. The Department of Inspections and Appeals, however, took no action and never mentioned the matter in an inspection report.

Werning says that's because the investigation failed to substantiate allegation of abuse.

• Late last year, Lisa M. Meyer , a certified nurse aide from Davenport, was fired from the Davenport Lutheran Home for the Aged after five co-workers claimed she had twisted the nipples of male residents or made sexually inappropriate comments. According to state records, one of the workers told administrators at the home that she had seen Meyer grabbing the penis of one male resident who was waving his arms in protest. Meyer faces criminal charges of sexual exploitation and neglect, but state inspection reports make no mention of abuse or neglect.

• Last October, Mary Luethje , a licensed practical nurse from Marshalltown, was fired from the Grandview Heights nursing home in Marshalltown. A resident had complained directly to an inspector that Luethje was sleeping while on duty. Other employees of the home reportedly told administrators they had seen Luethje sleeping as often as three times per night and for 10 to 45 minutes at a stretch. Luethje allegedly admitted that she slept on duty. The inspection agency, however, never mentioned the matter in any of its reports.

Advocates tell Vilsack: Check home inspections
By CLARK KAUFFMAN
REGISTER STAFF WRITER
July 10, 2004

A federal agency that says Iowa's nursing home regulators are failing to protect residents asked Gov. Tom Vilsack on Friday to investigate the matter.

Iowa Protection and Advocacy, a federally chartered organization that advocates for the mentally ill and the disabled, issued a report that alleges the Iowa Department of Inspections and Appeals is downgrading health and safety violations found in nursing homes.

The advocacy agency bases its findings on a comparison of the written reports made by the DIA's on-site inspectors to the published, final inspection reports issued by the department. The advocacy group says DIA administrators delete or downgrade certain violations before the public reports are issued.

At a news conference, Iowa Protection and Advocacy invited 52-year-old Scot Cohee of Des Moines to speak. Cohee, who uses a wheelchair and has multiple sclerosis, has lived in care facilities for more than 25 years. He said the homes rig the inspection process by calling in extra staff in advance of the inspectors' annual visit. Then, once the inspectors depart, the extra staff members leave. The quality of care returns to the point where there are food shortages and residents can't get assistance they need, Cohee said.

"It just about makes me sick," he said. "At meals, you're sent away hungry, and you go to bed hungry."

Last year, the federal government faulted Iowa for the predictable manner in which it scheduled some nursing home inspections.

Sylvia Piper, the executive director of the advocacy group, said Friday that the agency is asking Vilsack to look into its findings. A Vilsack spokesman declined to comment Friday, noting that the governor's staff had just received the report and had yet to read it.

Department of Inspections and Appeals officials flatly deny "downgrading" inspectors' findings, but they acknowledge that not all of those findings make their way into the department's final, published reports. The department says that's to be expected, as those findings must be reviewed to make sure they are supported by evidence and documentation.

Department spokesman David Werning said that because each allegation made by the department is subject to a series of appeals, the burden of proof that's required for each allegation can be as high as that found in court proceedings.

A Des Moines Register review of Iowa Workforce Development cases indicates that even in cases where nursing home workers have confessed to neglect or been criminally charged with abuse, the inspections department doesn't always sanction the home or disclose the matter in its published inspection reports.

For example, an eastern Iowa nurse's aide is currently facing criminal charges of sexual exploitation and neglect, but there is no mention of her alleged abuse of residents at Davenport Lutheran Home for the Aged in any of the DIA's published reports.

Werning said that can happen in cases where the department concludes that a nursing home responded appropriately to abuse and didn't contribute to its cause. In such cases, he said, the department still would take steps to have the abusers placed on the statewide registry of abusers, theoretically barring them from future employment as caregivers.

Last year, the General Accounting Office and the Office of Inspector General in the U.S. Department of Health and Human Services each said that final inspection reports issued in Iowa and some other states were routinely understating the seriousness of problems found in nursing homes.

Iowa Long-Term Care Ombudsman Debi Meyers said those reports and the findings of Iowa Protection and Advocacy all point to a larger problem with the regulation of nursing homes: secrecy and a lack of accountability.

"These reports each give us little peeks into this black box," she said. "The public has a right to know what is in that black box. Right now, the public doesn't have the access it needs to know how this process works and what goes into the decision making."

Grassley: Nursing home regulation corrupted
By CLARK KAUFFMAN
REGISTER BUSINESS WRITER
July 13, 2004

U.S. Sen. Charles Grassley says the nation's system of nursing home regulation is being eroded by state officials who pressure inspectors to downplay or overlook heath and safety violations.

The claim by the Iowa Republican is similar to that made last week by Iowa Protection and Advocacy, a federally chartered organization that advocates for the mentally ill and disabled.

The organization said in a new report that its examination of state inspection records showed that regulatory violations found by inspectors for the Iowa Department of Inspections and Appeals are being downgraded by department supervisors. Similar claims were made against the Iowa department last year by the U.S. General Accounting Office and by the Office of the Inspector General within the U.S. Department of Health and Human Services .

Grassley's comments were based on a separate investigation conducted by his staff.

Grassley said it appears to him that nursing home regulation has been "seriously corrupted" by the systematic downgrading of violations.

"It is apparent from our review that the survey and certification process upon which we rely for accurate, objective and independent data on the operation and activities of facilities is just plain broke," he said. "It has been corrupted by unscrupulous individuals, and we need to restore the integrity of the system in every state and locale."

David Werning, a spokesman for the Department of Inspections and Appeals, said the agency would have no comment on Grassley's allegations. The department has denied "downgrading" violations found by its inspectors, but Werning says potential fines and charges are not imposed in cases where inspectors have either failed to document their findings or have misapplied certain regulations.

Two years ago, the Iowa department declined to fine a nursing home where one resident's abdomen was reported to be infested with maggots.

The alleged infestation was discovered when the resident visited a dialysis clinic, where a nurse and physician later claimed to have cleaned 30 maggots from the site of the man's abdominal feeding tube. The inspections department cited the home only for failing to follow a doctor's order related to hygiene, and no fine was imposed.

Grassley's comments are contained in a letter to Mark McClellan, head of the U.S. Centers for Medicare and Medicaid Services, which oversees the states' enforcement of federal nursing home standards. Grassley told McClellan that last year he instructed his staff to interview nursing home inspectors from around the nation to obtain their views on the regulatory process.

Although Grassley's staff tried to interview Iowa inspectors, none would talk with the senator's aides, said Jill Kozeny, a spokeswoman for Grassley. All 20 who ultimately agreed to talk with Grassley aides were from other states.

Grassley said his staff reported back to him with stories of inspectors who question the integrity and effectiveness of the regulatory process.

Inspectors "routinely stated that they were 'instructed' by their superiors to downgrade citations," Grassley said, or to not write up nursing homes for certain high-level deficiencies.

He said some former inspectors resigned or retired "out of sheer disgust" at the way state government officials routinely tied their hands on the enforcement of regulations.

He told McClellan that some inspectors complained of an unspoken "political presence" that has resulted in pressure to systematically overlook or downgrade violations. Some inspectors complained that because high-level violations were routinely omitted from the final, published inspection reports, any attempt to charge homes for those violations was perceived as trying to "rock the boat."

Grassley said it also appears that investigations made by state regulators are hampered by predictable inspection schedules and by a tendency to accept the word of nursing home administrators over the complaints made by residents or their relatives.

Officials at the Centers for Medicare and Medicaid Services told Gannett News Service that they "will take appropriate further action to improve the quality of nursing home care" after Grassley's letter is received.

Iowa's lost integrity: Let's get it back
By REGISTER EDITORIAL BOARD

July 25, 2004

A place to begin: Stop overlooking nursing-home violations

A powder was poured into the elderly man's nose, eyes and mouth. He was then wrapped in a urine-soaked sheet, and his wheelchair was rolled in front of an air conditioner. When he shivered and protested, he was threatened with worse.

Iraqi prison? Nope. An Iowa nursing home. The tormentors were "caregivers."

Elsewhere in Iowa, a nurse pulled the bandage off a man scheduled for kidney dialysis and found an infestation of maggots swarming over the flesh of his feeding-tube opening. A complaint was filed against the nursing home paid to care for the man. But the home paid no fine.
Federal officials monitoring nursing homes said Iowa leads the nation in the number of nursing-home violations that are reported by inspectors and then erased by higher-ups.

Welcome to Iowa, where anything goes.

Where a habitual speeder nailed by a state trooper can have his ticket fixed and avoid losing his license by dropping a bundle of cash on local county shakedown artists. And the Iowa attorney general sits on his hands.

Where the Legislature solves pollution problems by passing laws to protect the polluters.
Where an angler risks a significant fine for pulling up one too many fish, but a livestock operation whose manure spills kill them by the thousands can pay its fines out of petty cash.

Where taxpayers spend millions building truck-weighing stations along the Interstates, but you're about as likely to find the scales open as you are to win the lottery.

What gives?

What happened to the hard-nosed, no-nonsense attitudes that built the Iowa image of integrity? When did we become patsies? When did we decide to let everything slide? And why?

The ongoing scandals in the weak enforcement of Iowa nursing-home regulations offer a place to start asking, because a society's treatment of the most helpless of its members provides such an illuminating insight into that society's character. In ways we look very good indeed; our 3,500-member patient-advocate system was the first -and still the only one of its kind -in the nation, and progressive homes take pride in developing innovative ways to involve residents in community activities. No one doubts that the majority of Iowa nursing homes offer decent care.

But in fiscal 2002, more than 300 complaints of abuse in nursing homes were referred to Iowa criminal investigators. That's terrible. Not one criminal charge was filed as a result. That's worse.

Comes now a report from the Government Accountability Office charging that many Iowa nursing homes harbor "serious fire hazards." Nationwide, 59 percent of homes flunked their most recent fire-safety inspections; Iowa looks even worse, at 80 percent. More than 10 percent of Iowa homes lack the required sprinkler systems. The response from the spokesman for the Iowa Healthcare Association, which represents a majority of Iowa nursing homes, is that if taxpayers want sprinklers, taxpayers will

have to chip in. The $102 per day that they now give to support half of Iowa's nursing home population on welfare won't stretch.

You're paying millions per year in state taxes alone to buy quality care. You're also, in some instances, buying neglect, risk and abuse.

You're hiring the troopers who take on the dangerous job of enforcing our laws and then see those laws misused to profit local "charities."
You pay for the highways that overweight trucks shatter while roaring on past the unmanned weigh scales.

You may be paying with your health for breathing air befouled by certain livestock operations, whose owners may live 1,000 miles upwind.

This in proud, upright, incorruptible Iowa, whose character was toughened by economic and drought disasters, wartime sacrifices and rural revolution, and now finds its citizenry and enforcement agencies so selfish, so indifferent, so uninvolved that they can't or won't demand humanitarian concern for our elderly, and a decent respect for the rules that govern a just society.

Anything goes. And our integrity goes with it.

Let's get our integrity back. Begin by enforcing the nursing-home rules instead of routinely forgiving violations.